

Andrews University

## Digital Commons @ Andrews University

---

Dissertations

Graduate Research

---

2006

### Amish Childbearing Beliefs and Practices and the Implications for Nurse-Midwives as Servant-Leader Care Providers

Victoria L. Wickwire  
*Andrews University*

Follow this and additional works at: <https://digitalcommons.andrews.edu/dissertations>



Part of the [Medicine and Health Commons](#)

---

#### Recommended Citation

Wickwire, Victoria L., "Amish Childbearing Beliefs and Practices and the Implications for Nurse-Midwives as Servant-Leader Care Providers" (2006). *Dissertations*. 1542.  
<https://digitalcommons.andrews.edu/dissertations/1542>

This Dissertation is brought to you for free and open access by the Graduate Research at Digital Commons @ Andrews University. It has been accepted for inclusion in Dissertations by an authorized administrator of Digital Commons @ Andrews University. For more information, please contact [repository@andrews.edu](mailto:repository@andrews.edu).



Seek Knowledge. Affirm Faith. Change the World.

Thank you for your interest in the

**Andrews University Digital Library  
of Dissertations and Theses.**

*Please honor the copyright of this document by  
not duplicating or distributing additional copies  
in any form without the author's express written  
permission. Thanks for your cooperation.*

Andrews University

School of Education

AMISH CHILDBEARING BELIEFS AND PRACTICES  
AND THE IMPLICATIONS FOR NURSE-MIDWIVES  
AS SERVANT-LEADER CARE PROVIDERS

A Dissertation

Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

by

Victoria L. Wickwire

January 2006

UMI Number: 3213132

Copyright 2006 by  
Wickwire, Victoria L.

All rights reserved.

#### INFORMATION TO USERS

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleed-through, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

**UMI<sup>®</sup>**

---

UMI Microform 3213132

Copyright 2006 by ProQuest Information and Learning Company.

All rights reserved. This microform edition is protected against  
unauthorized copying under Title 17, United States Code.

ProQuest Information and Learning Company  
300 North Zeeb Road  
P.O. Box 1346  
Ann Arbor, MI 48106-1346

©Copyright by Victoria L. Wickwire 2006  
All Rights Reserved

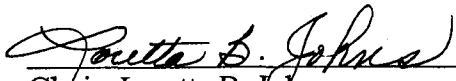
AMISH CHILDBEARING BELIEFS AND PRACTICES  
AND THE IMPLICATIONS FOR NURSE-MIDWIVES  
AS SERVANT-LEADER CARE PROVIDERS

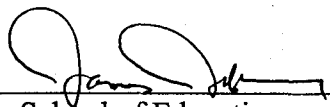
A dissertation  
presented in partial fulfillment  
of the requirements for the degree  
Doctor of Philosophy

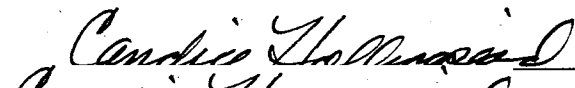
by

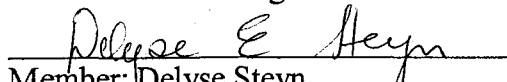
Victoria L. Wickwire

APPROVAL BY THE COMMITTEE:

  
Chair: Loretta B. Johns

  
Dean, School of Education  
James Jeffery

  
Member: Candice Hollingshead

  
Member: Delyse Steyn

  
External: Mary Ann McNeilus, M.D.

2/6/06  
Date approved

**ABSTRACT**

**AMISH CHILDBEARING BELIEFS AND PRACTICES  
AND THE IMPLICATIONS FOR NURSE-MIDWIVES  
AS SERVANT-LEADER CARE PROVIDERS**

**by**

**Victoria L. Wickwire**

**Chair: Loretta B. Johns**

## ABSTRACT OF GRADUATE STUDENT RESEARCH

Dissertation

Andrews University

School of Education

Title: AMISH CHILDBEARING BELIEFS AND PRACTICES AND THE  
IMPLICATIONS FOR NURSE-MIDWIVES AS SERVANT-LEADER CARE  
PROVIDERS

Name of researcher: Victoria L. Wickwire

Name and degree of faculty chair: Loretta B. Johns, Ph.D.

Date completed: January 2006

### Problem

The knowledge, beliefs, and practices associated with childbearing among Amish women from their perspective are not widely known. The available research on Amish childbearing health practices does indicate that these women are at high risk for problems during the childbearing period. This indication, coupled with both a general mistrust of outsiders and the Amish separateness from society at large, creates opportunities for misunderstandings. These misunderstandings in turn have created challenges for care providers outside the Amish culture who are seeking research-based knowledge about what constitutes culturally congruent childbearing care from the Amish woman's perspective. It is unknown how using a Servant-Leadership model to provide care in a culturally congruent manner could decrease misunderstandings and build mutual



trust and respect so that opportunities for risk reduction during childbearing may be realized.

### Method

A qualitative ethnographic design was chosen to facilitate exploration and understanding of Amish women's perceptions of their childbearing beliefs and practices, as well as the implications for care providers who seek to provide care in a culturally congruent manner. The characteristics that are central to a meaningful practice of Servant-Leadership were explored using an ethnographic approach. The use of semi-structured interview questions and field observation assisted in exploring the constructs of the three research questions. These explorations and analysis of the data were discussed and conceptualized through case study representation.

### Results

The 10 guiding principles of Servant-Leadership were found to be congruent with the Amish ways as stated from the perspective of these Amish women. Utilizing these principles afforded opportunities for nurse-midwives as Servant-Leader care providers to positively impact the childbearing health care of the Amish women in this community by facilitating educational opportunities during childbearing.

### Conclusions

The 10 guiding principles of Servant-Leadership facilitated the construction of the Concept of Care Model which supplies the non-Amish care provider a visual aid to incorporate when planning provision of culturally congruent care to Amish women. The model includes caring, culturally sensitive, and informed concepts geared toward

solidifying a congruent partnership between the two different cultures. The Servant-Leader model provided a framework from which both the Amish childbearing woman and the nurse midwife felt comfortable to apply the 10 characteristics of Servant-Leadership, incorporating these culture-caring principles as needed into their care plan to build a trusting relationship.

Dedicated to the Master Servant-Leader—the Lord Himself—  
and  
To my husband Bruce  
without whom my study would have been impossible.

Thank you both for blessing the idea with guidance and caring,  
shaping it with love and encouragement . . .  
And for being wonderfully güt friends

## TABLE OF CONTENTS

LIST OF TABLES .....	vii
ACKNOWLEDGMENTS .....	viii
Chapter	
1. INTRODUCTION .....	1
Background .....	1
The Problem .....	2
Statement of the Problem .....	7
Purpose of Study .....	7
Research Questions .....	8
Rationale for the Study .....	8
Theoretical Framework: The Servant-Leadership Model .....	10
Significance of Study .....	12
Basic Assumptions .....	13
Delimitations .....	13
Limitations .....	14
Definitions .....	15
Methodology .....	20
Summary .....	22
Organization of the Study .....	23
2. REVIEW OF RELATED LITERATURE .....	25
Culture .....	26
The Amish Culture .....	30
Ethno-Historical Origins .....	32
Ethno-Religious Origins .....	33
Ethno-Educational Origins .....	35
Ethno-Social Origins .....	37
Health Care Beliefs and Practices of Amish Women .....	39
Culturally Sensitive Health Care .....	40
Provision of Culturally Congruent Care to the Amish .....	45
Servant-Leadership .....	51
The Servant-Leadership Model .....	56
Summary .....	67
3. METHODOLOGY .....	70
Introduction .....	70
Research Design .....	70

Description of the Population and Sample Selection .....	72
Domain of Inquiry (Stated Problem) .....	73
Qualitative Instrumentation (Validity and Reliability) .....	74
Pilot Study .....	79
Background of the Pilot Study .....	79
Pilot Study Development and Prior Work Experience .....	79
Pilot Study Development and Servant-Leadership .....	80
Pilot Study Overview .....	81
Final Research Questions .....	82
Data Collection and Analysis .....	85
Summary .....	90
 4. RESULTS .....	 91
Overall Purpose of the Study .....	91
Case Study 1 .....	94
Entry Vignette: Background .....	94
Issue Development .....	96
Research Question 1/Theme 1 .....	96
Research Question 2/Theme 2 .....	97
Research Question 3/Theme 3 .....	98
Assertion .....	99
Triangulation Source for Assertion .....	99
Case Study 2 .....	101
Entry Vignette: Background .....	101
Issue Development .....	104
Research Question 1/Theme 1 .....	104
Research Question 2/Theme 2 .....	104
Research Question 3/Theme 3 .....	105
Assertion .....	105
Triangulation Source for Assertion .....	106
Case Study 3 .....	107
Entry Vignette: Background .....	107
Issue Development .....	108
Research Question 1/Theme 1 .....	108
Research Question 2/Theme 2 .....	108
Research Question 3/Theme 3 .....	109
Assertion .....	110
Triangulation Source for Assertion .....	111
Case Study 4 .....	114
Entry Vignette: Background .....	114
Issue Development .....	115
Research Question 1/Theme 1 .....	115
Research Question 2/Theme 2 .....	115
Research Question 3/Theme 3 .....	116
Assertion .....	117
Triangulation Source for Assertion .....	117
Case Study 5 .....	118
Entry Vignette: Background .....	118

Issue Development .....	120
Research Question 1/Theme 1 .....	120
Research Question 2/Theme 2 .....	121
Research Question 3/Theme 3 .....	121
Assertion .....	122
Triangulation Source for Assertion .....	123
Case Study 6 .....	124
Entry Vignette: Background .....	124
Issue Development .....	125
Research Question 1/Theme 1 .....	125
Research Question 2/Theme 2 .....	126
Research Question 3/Theme 3 .....	127
Assertion .....	128
Triangulation Source for Assertion .....	129
Case Study 7 .....	130
Entry Vignette: Background .....	130
Issue Development .....	131
Research Question 1/Theme 1 .....	131
Research Question 2/Theme 2 .....	132
Research Question 3/Theme 3 .....	133
Assertion .....	133
Triangulation Source for Assertion .....	134
Summary.....	135
5. SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS .....	138
Introduction .....	138
Methodology.....	140
Representations of Data .....	143
Discussion of Findings .....	147
Relevance of the Servant-Leadership Model .....	147
Relevance of the Literature Review .....	159
Implications .....	164
Recommendations for Future Research and Practice .....	168
Appendix	
A. LETTERS .....	173
B. RESEARCH AND INTERVIEW QUESTIONS .....	177
C. FIELD NOTES TABLE WITH INTERVIEW SUMMARY FROM PILOT STUDY .....	182
REFERENCE LIST .....	186
VITA .....	195

## LIST OF TABLES

1. Synopsis of Significant Cultural Studies on the Amish . . . . .	47
2. Major Events in the Life and Career of Robert K. Greenleaf. . . . .	54
3. Correlation of Interview Questions With Research Questions and Their Relationships With the 10 Characteristics of Servant-Leadership . . . . .	84

## ACKNOWLEDGMENTS

This work has truly been a collaborative effort. Since it is a Servant-Leadership principle to publicly acknowledge others, I do not take this privilege lightly. I feel a tremendous debt of gratitude to those who helped make this research possible. All of you gave so much of yourselves; you listened, you empathized in just the right doses, you persuaded me at just the right time, you encouraged healing by reminding me to have balance, you showed awareness through your expert knowledge and gifts, you helped me conceptualize this dream and to keep moving, you had wonderful foresight, you lived stewardship by giving your time and the gift of yourselves. You were committed to helping me grow, and we built community together in this remarkable journey. A heartfelt thank-you to Dr. Loretta Johns (my true Servant-Leader Chair), Dr. Candice Hollingsead (my methodologist and knowledgeable kind motivator), Dr. Delyse Steyn (my content specialist and wise compassionate counsellor), Mrs. Christina Boyd (my patient, loving editor and dear daughter), Mrs. Ashley Sikora (my constant encourager, prayer partner, and dear daughter), Mrs. Bev Cobb (my encourager, coach, and friend), Dr. Karon Schwartz (my friend, who loves the Amish as I do and graciously lent me her books), and Dr. Steven Nolt who took the time to share his insights on the Amish with me. A special thanks to Mrs. Cynthia Helms (my friend, and librarian information specialist exemplar), Mrs. Bonnie Proctor (a wonderful Servant-Leader editor in her own right), Dr. William Mason (a friend and mentor who also treasures the life-philosophy of Servant-Leadership), Mr. Larry Spears (a friend whose penning of the 10



characteristics from Mr. Robert Greenleaf's works has led a forever transformation in my heart), and Dr. Madeleine Leininger and Dr. Larry Purnell for taking time to talk with me and encourage me as well as countless other students who are interesting in researching and providing culturally congruent care. I also am indebted to the many special women and men who shared their life stories so that others might see, as I have, the quiet and tranquil beauty that lives in the heart and lives of the Amish. And thank you, Dr. Mary Ann McNeilus and Mr. Marnelle McNeilus, for sharing your home and giving me the opportunity to experience firsthand the joy and satisfaction you both have found in being care providers in the truest sense to a very special community of people.

## CHAPTER 1

### INTRODUCTION

#### **Background**

The scarcity of information on childbearing from the perspective of women in the Old Order Amish religious subculture (hereafter referred to as Amish) is regrettable. This sort of valuable information is needed by care providers who desire to provide both sensitive and meaningful culturally congruent care. Only two dissertation studies, Miller (1997) and Nelson (1999), describe childbearing health practices using examples exclusively from the Amish women themselves.

Amish women are believed to be at high risk for problems during their childbearing period (Fuchs, Levinson, Stoddard, Mullet, & Jones, 1990; Miller, 1997). Birthing large families with closely spaced pregnancies and increasing maternal age during childbearing, coupled with the desire to refrain from adding financial burdens to the family, are contributing factors to this increased risk for pregnancy complications (Miller, 1997). Miller concluded that not seeking early and frequent prenatal care is an additional risk factor, often stemming from a mistrust of traditional health care or a general reluctance due to the inconveniences—including distance—associated with traditional health care. Nelson (1999) illustrated how Amish childbearing women informants from her study did not feel that they were receiving culturally sensitive health care from the non Amish medical community.

### **The Problem**

Amish women who are at risk during childbearing may not be afforded opportunities to learn about risk reduction within the educational, social, and ethno-religious framework of their culture. The ethno-religious and socio-cultural environment of the Amish strongly influences decision-making during the childbearing time (Kraybill, 1998; Schwartz, 2002). Campanella, Korbin, and Acheson (1993) found that Amish women do not automatically reject medical technology, but selectively determine what best would meet their individual and cultural needs in childbearing. The Amish community's movements toward change usually have been initiated in response to outside pressures.

Historically, most Amish deliveries were attended in the homes by physicians, Amish lay midwives, lay practitioners, and non-Amish lay midwives. Physicians who provided home care for the Amish have retired or moved into hospital settings, and interesting trends have emerged. Some Amish communities have built Amish out-of-hospital birth centers to meet the needs of their community, utilizing physicians and certified nurse-midwives. Nurse-midwives who work at these birth centers go to the homes for prenatal visits and home births, and accommodate the use of herbs and complementary therapies in their practice. This has been well received by the Amish due to their preference for self-care, natural remedies, and the use of herbs for illness and health maintenance (Schwartz, 2002). The practice also is economically affordable when compared to hospital and private physician care.

Since Amish formalized education stops after eighth grade, and technology such as the Internet is not used, the education of women with regard to childbearing is

generally obtained either from experience or from older Amish women. Campanella et al. (1993) asked Amish women if they would like more education regarding health. Ninety-three percent ( $n=14$ ) of the women stated that they would like more information from the professional sector. The study also discussed the Amish perception of childbirth as a serious life event and how Amish women value the presence of an experienced and skilled birth attendant. In this study, the Amish women felt it was important to look at health-seeking behavior for childbirth by weighing perceived risks and benefits of all options with factors such as cost and family resources. Hospital births were negatively regarded due to the lack of privacy, high cost, and chance of being given orders by health care professionals with no consideration of the Amish beliefs and practices. Miller (1997) and Nelson (1999) also affirmed that Amish women do desire to have a sense of safety in the event that any complication may arise.

Amish women uphold the beliefs of their culture; they are a separate, chosen, or “peculiar” people. These beliefs are based on the Biblical principle whereby Christians are encouraged by God not to conform to worldly customs. This separation is illustrated by the lifestyle, dress, religious beliefs, and health care practices engaged in by Amish women (Hostetler, 1993; Kraybill, 1989; Schwartz, 2002). Schwartz (2002) referred to these beliefs as the “*ordnung*,” an unwritten set of rules that are fully understood and defined by the lifestyle and conduct in all aspects of an Amish person’s life.

The Amish are more open to health care providers who express caring attitudes and are sensitive to Amish-specific health care beliefs and practices (Hewner, 1993; Miller, 1997; Nelson, 1999; Schwartz, 2002; Wenger, 1988; Yoder, 1984). Both Miller (1997) and Schwartz (2002) concluded that the health care provider must be culturally

sensitive and non-critical, as well as knowledgeable of the ethno-religious beliefs and practices of the Amish, in order to provide culturally congruent care. Miller (1997) believed that through education, mutual respect, negotiation, and trust the health care provider can begin to give culturally congruent care.

Schwartz (2002) also proposed that it was important for a health care provider to be congenial, non-condescending, and have non-critical attitudes toward Amish religious beliefs and health care practices. Schwartz (2002) was able to replicate Hostetler's (1993) finding that nurses are, as health care professionals, generally accepted by the Amish as being knowledgeable and trustworthy. Schwartz also concluded that nurses who are not critical of the Amish culture will have an enhanced ability to build trust and thus provide culturally congruent care to Amish women. Interestingly, the significant hallmarks of nurse-midwifery practice are health education, disease prevention, and the promotion of health care within a partnership that is sensitive to the cultural needs of the woman and her family (American College of Nurse-Midwives, 2003).

Due to the Amish separateness from society at large, it was unknown how using a Servant-Leadership model might be useful in providing culturally congruent health care in a manner that would decrease misunderstandings and build trust. For the purposes of this study, the operational definition for culturally congruent means that the health care is respectful, accepting, and congruent with the client's culture and incorporate the client's traditional beliefs and practices (Andrews & Boyle, 2002; Giger & Davidhizar, 2004; Leininger, 1995, 2002; Leininger & McFarland, 2002, 2006; Lemon, 2002; Purnell & Paulanka, 1998; Purnell, 1999).

An interview with Amish childbearing women during a qualitative research class assignment facilitated an initial understanding and desire to know if using a Servant-Leadership model might make this possible. Servant-Leadership is a practical philosophy that encourages trust, collaboration, and the ethical use of empowerment while developing partnerships.

One of the women interviewed (hereafter referred to as “RF”) had left the Amish religion and joined the Mennonite society because she wanted an education beyond the eighth grade. RF has since become an educator herself, and though not specifically familiar with Spears’ 10 characteristics of Servant-Leadership (Spears & Lawrence, 2002), felt she was able to relate with the characteristics of Servant-Leadership and how they aligned from her opinion with the Amish ways or worldview.

RF cited many incidents where the essence of Servant-Leadership characteristics were shared and practiced within her Amish home and community. She felt that all 10 characteristics would offer help in creating more culturally congruent care among Amish childbearing women. RF said, “No one outdoes the Amish in humility; . . . the desire to live simply, in tune with nature, and to put others before yourself is the way of the Amish” (RF, personal communication, January 26, 2003).

RF also defended the role of the nurse as an important and accepted care provider in the Amish way of life. Nurses are considered knowledgeable and their suggestions are both taken seriously and valued, especially if the nurse is accepting and not critical of the Amish culture. RF felt that a care provider who used a Servant-Leadership model of care would work well with patients in an ethno-religious culture that promotes servant caring, empathy, listening, healing, and commitment to the individual and community. RF

further postulated that when the Servant-Leadership model was viewed from an Amish cultural perspective, it could be very effective as a culturally sensitive tool in building strong health care partnerships between the Amish and non-Amish care providers (RF, personal communication, January 26, 2003).

This interview provided further impetus to explore how using a model that arose from Anabaptist roots may have relevance for Amish childbearing women. Amish childbearing women may not necessarily have had the opportunity of constructing their own culturally congruent framework for childbearing health care. Erroneous views from the experiences of others (outside care providers) may have been imposed on them since the Amish do not go for formal education and do not have licensed Amish care providers. Research studies support that the Amish tend to mistrust anyone other than Amish, along with outside health care, and it is important to understand the Amish culture in order to provide appropriate and sensitive care to this culturally diverse group (Blair & Hurst, 1997; Campanella et al., 1993; Dellasega, Hupcey, & Fisher, 1999; Hostetler, 1999; Kraybill & Bowman, 2001; Palmer, 1992; Wenger, 1988; Yoder, 1984).

Research substantiates the importance of the health care provider demonstrating affective characteristics or attributes when desiring to build trust with their Amish clients. The Amish appreciate and relate to nurses who are warm, open, receptive, friendly, and take time to listen, empathize, show awareness of healing preferences, and conceptualize Amish health care beliefs into the plan of care (Beachy, Hershberger, Davidhizar, & Giger, 1997; Buccalo, 1997; Dellasega et al., 1999; Miller, 1997; Nelson, 1999; Schwartz, 2002; Wenger, 1988; Yoder, 1984).

### **Statement of the Problem**

The research knowledge, beliefs, and practices associated with childbearing from the Amish woman's perspective are limited. Studies that have specifically focused on childbearing health practices from the Amish woman's perspective suggest that further research is needed (Campanella et al., 1993; Miller, 1997; Nelson, 1999).

The literature suggests that care providers need to be more understanding of the complexities of a culture when desiring to give culturally congruent care that will be meaningful. Such care also will be more likely to create opportunities for health teaching and in preventing negative, unfavorable, or inappropriate care and healing practices (Leininger, 1995; Lemon, 2002; Reynolds & Leininger, 1993; Schwartz, 2002; Wenger, 1988; Yoder, 1984). Wenger (1988) identified the need of nurses and other care providers outside the Amish culture for research-based knowledge about culture-care meanings and functions in order to provide culturally-congruent care. However, no studies have examined how using a Servant-Leadership model to provide sensitive culture care (interrelating and maintaining their cultural practices within a framework of caring) might decrease misunderstandings and build mutual trust and respect during the childbearing time.

### **Purpose of Study**

The purpose of this study was to explore the health care beliefs and practices of Amish women related to childbearing from their perspective, and how nurse-midwives as Servant-Leaders may gain insight for the teaching and promotion of health care among Amish women. The goal was to use qualitative research and ethnography to gain knowledge and insight about Amish childbearing women within the context of their



religious and socio-cultural environment. Knowledge derived from the research data will lay the groundwork for understanding the childbearing health needs of Amish women and the implications for care providers who wish to give culturally congruent care to Amish childbearing women.

### **Research Questions**

The following research questions were used as guidelines during the course of this ethnographic study:

1. How did the ethno-cultural beliefs of Amish women influence their health care during childbearing?
2. Was there any congruence between the Servant-Leadership model and Amish childbearing women's ethno-cultural beliefs?
3. What were the culturally congruent guiding principles of Servant-Leadership that could assist nurse-midwives in their role as educators and promoters of health care to Amish childbearing women?

### **Rationale for the Study**

The Amish in the United States have a unique culture that influences the health beliefs and practices of its childbearing women. Certain Amish practices promote healthy pregnancy outcomes, such as the extensive psychosocial support system of the family and community; abstinence from smoking, alcohol, and drugs; and the value placed on motherhood and children (Campanella et al., 1993). Campanella et al. (1993) also identified perinatal risk factors prevalent among Amish childbearing women that increased their risk factors during pregnancy. These factors included short birth intervals,

grand multiparity, increased births to older women, consanguinity (blood-related marriages), increased rate of twinning, a diet often high in fats and sugar, obesity, lack of medical insurance, late entry to prenatal care, and attending fewer prenatal visits by choice. Consequently, traditional non Amish health care providers have found it a challenge to provide culturally congruent childbearing care that met the health needs of this ethno-religious population.

An understanding of the Amish childbearing woman's perspective may provide insight into how using a theoretical model, such as the Servant-Leadership model, could have potential in contributing to a decrease in misunderstandings, thereby better enabling the nurse-midwife/care provider to implement culturally sensitive and positive pregnancy-outcome care. Using the Servant-Leadership model has been shown to both build trust and facilitate partnership in business (Mason, 2002; Russell, 2000; Spears & Lawrence, 2002). Before attempting to implement interventions such as education about childbearing, health promotion, or prevention, the care must be culturally acceptable to the Amish. If it is not considered acceptable, the practice would not be considered or followed (Miller, 1997; Nelson, 1999; Schwartz, 2002; Wenger, 1988; Yoder, 1984). Utilizing a culturally congruent model would have value for a people group who desire more information and prefer care providers who are sensitive to their ethno-religious beliefs.

Amish culture care and community building are at the core of the Amish worldview and social structure; these are basic principles that guide choices in everyday life. The emphasis on community building and culture care may cause a woman to withhold or not share her personal health care concerns regarding childbearing. Yoder

(1984) described Amish health care-seeking behaviors and the characteristics the Amish prefer in nurse practitioners. Yoder suggested that Amish women prefer a nurse practitioner who expresses a caring attitude with good interpersonal skills and who understands their culture.

In her study of breast-health and practices among Amish women, Schwartz (2002) found that the ability for nurses and nurse researchers to provide culturally congruent care was essential in building relationships. In the context of breast care, Schwartz found Amish women were more open and receptive to education if certain practices were employed. These practices included showing concern for the Amish beliefs by supporting holistic healing, demonstrating cultural sensitivity, commitment to nurturing, and building a partnership with the client. Schwartz (2002) encouraged care providers to treat Amish patients with respect and non-judgmental attitudes, particularly when related to their religious, folk, and alternative health practices.

### **Theoretical Framework: The Servant-Leadership Model**

The principles of Robert K. Greenleaf's Servant-Leadership theory (Greenleaf, 1977) have been summarized into 10 characteristics by Larry Spears, the Executive Director of the Robert Greenleaf Center in Indianapolis, Indiana. Spears (1998) has written over 300 articles, essays, and book reviews on Servant-Leadership and, after years of carefully considering Greenleaf's original writings, identified a set of 10 characteristics that are critical to the meaningful practice of Servant-Leadership. The characteristics offer principles that provide guidance for ethical and caring behavior while enhancing personal growth.

These 10 characteristics were used as guidelines throughout this study. First, the characteristics were used to guide in the construction of open-ended questions and observations during research. Second, the model was used to compare and explicate the knowledge-base and perceptions of Amish childbearing women with regard to expectations of care providers in the management of their health care, and to determine how those expectations may relate to the 10 characteristics of Servant-Leadership. Third, the 10 characteristics of the Servant-Leadership model provided a framework from which to draw possible implications for nurse-midwives who hope to facilitate the education and health care choices of Amish women during childbearing. Fourth, the model created a venue in which to examine characteristics of caring that were meaningful for the Amish women.

Spears and Lawrence (2002) found the 10 characteristics of the Servant-Leadership model applicable in building relationships with others; it seeks to involve others in decision-making and is strongly rooted in ethical and caring behavior. This creates several possibilities for the relevant and practical use of Servant-Leadership in health care partnerships as well. The following are key characteristics for application of the model: the value of listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of people, and building the community.

Greenleaf (1977) referred by name to many of the above characteristics in his original essays on *The Servant as Leader*, although he did not formulate them into any particular order of significance. Greenleaf (1977) advocated that in order to build relationships in any community as a viable partnership, the Servant-Leader must show

the way, not utilizing mass movements, but through demonstrating his own caring and unlimited giving of self to that specific related group. The caring is best communicated if the one being served also is personally involved in understanding that the search for wholeness is something both parties value (Greenleaf, 1977).

Each of the above precepts espouses both power and promise for the care provider who possesses a deep commitment to building relationships. The implication for the care provider seeking entry into the Amish culture for purposes of education and management of care is such that a care provider must establish a relationship of trust and caring with the Amish people. Hostetler (1993) and Kraybill (1998) both advocated the best way to understand the values and life-ways of the Amish is to understand the importance that religion and community culture have and hold in the lives of these people.

### **Significance of Study**

Further knowledge is needed to understand childbearing beliefs and health practices from the Amish woman's perspective before culturally congruent care with restructuring or creating new patterns of health care may be implemented. The significance of this study lies in its ability to expand the knowledge base of health care providers, especially nurse-midwives, as they lead out in care during the personal and private time of childbearing for Amish women.

Using a Servant-Leadership model supplies the care provider with a lens through which to examine the Amish childbearing woman's perspective of what culturally congruent care entails.

### **Basic Assumptions**

Based on a review of the literature and the experiences of researchers familiar with the Amish culture, assumptions were composed to provide a framework pertinent to the study:

1. Decision-making processes for Amish women are influenced by their ethno-historical, educational, social, and religious health care beliefs and practices concerning childbearing.
2. Amish childbearing women follow principles of the *ordnung* that are beneficial for sharing with care providers; sharing of the *ordnung* allows care providers to better understand the Amish woman's childbearing beliefs and practices.
3. Providing and applying culturally congruent care creates fewer opportunities for misunderstanding, and builds mutual trust and respect between Amish women and their care providers.

### **Delimitations**

This study was purposely delimited to an area in the Midwestern United States where I was not known as a nurse-midwife and the Amish participants were not known to me to help prevent personal bias. The gatekeeper for the Amish women lived in the area where the interviews and observations took place among Amish childbearing women, thus saving time and resources for the collection of data and recruitment of willing participants of the Old Order Amish culture.

### **Limitations**

The purposeful sampling procedure required for a qualitative ethnographic analysis allowed me to focus on a specific group of Amish individuals who generally do not grant interviews to people outside their culture, thus limiting the number of participants involved. Since my goal as the ethnographer was to participate as much as possible, seeking both to know and understand the essence of the women's meaning of their lived experiences, it was important that the participants trusted me. The willingness of these women to actually share such personal experiences with an outsider was unlikely unless they were approached first by an already known, accepted, and trusted person who could introduce me and open the door for candid conversation.

There was potential for bias in analysis of the data; participants may have had varying comfort levels with regard to sharing their beliefs and practices. Conclusions were drawn directly from the dialogue, and care was taken not to change the content in relation to the context. Respondents potentially may have slanted their responses to sound more socially acceptable and complementary to their Amish community.

There also was possible personal bias resulting from my professional practice as a nurse-midwife and my history of working with Amish childbearing families. Attempts were made to relate the story as it was told, from the Amish women's perspective. One year later, a return trip was made to the same Amish community to internally validate the data. The second trip allowed for a reconnection with the Amish women, the opportunity to share with them synopses of their stories, and to determine if the findings extrapolated from those stories were congruent with their Amish reality.

The data (themes and tentative interpretations) were provided to the women in narrative form, and they were asked to verify if the stories truly were captured from their perspective and meaning. This opportunity to check for internal validity was important in validating the ethno-cultural interpretation of their shared narratives. Creswell (2003) recommended that a primary strategy, such as member checking, should be done to determine the accuracy of qualitative findings. Taking the descriptions and themes back to the participants and asking them to verify whether the narrative was accurate added validity to the findings. This type of validity is a strength associated with qualitative research.

### **Definitions**

The following terms as defined for this study served to focus the domain of inquiry: exploring the health care beliefs and practices of Amish childbearing women and the implications for nurse-midwives as servant care providers. The definitions relate to both the conceptual framework of Servant-Leadership and Culture Care Theory in assessing culture and health, and in discovering meanings within the context of the analysis.

**Amish (Old Order):** A group of individuals born, reared, and presently living and participating in the Old World Amish ethno-religious, social, and educational culture. The Amish desire to adhere to the old traditions, based on an unwritten set of rules known as *ordnung*. These unwritten rules embody the teachings and practices of the church and are based on Biblical principles (Schwartz, 2002).

**Certified Nurse-Midwife:** An individual educated in the two disciplines of nursing and midwifery, certified by the American College of Nurse-Midwives. The



nurse-midwifery practice is the independent management of essentially normal newborns and women at all stages of the childbirth process: pre-conception, prenatal (antepartal), labor and delivery (intrapartal), immediate post-delivery care (postpartum), and gynecological (well-woman) care (Varney, 1987).

The art and science of midwifery are characterized by 16 hallmarks, many of which focus on promoting care within a client partnership that supports their individual rights and self-determination within the boundaries of safety. These hallmarks of practice are in accordance with eight standards of care that emphasize health education, health promotion, and disease prevention within a delivery system that fosters safe, satisfying, and culturally competent care (American College of Nurse-Midwives, 2003).

**Characteristics:** A trait or quality or attribute. An attribute is an inherent characteristic. These two terms are used interchangeably in this study as both Anthropology and Nursing use the terms synonymously (*Merriam Webster Online Dictionary & Thesaurus*, 2005; Dr. Larry Purnell, personal communication, November 23, 2005; Dr. Madeleine Leininger, personal communication, November 25, 2005).

**Childbearing:** The time period in a woman's life in which she actively participates in the process of giving birth, including the prenatal, labor and delivery, and postpartum time, also known as the antepartal, intrapartal, and postpartal time (Varney, 1987).

**Culture:** The holistic totality of socially transmitted behavioral patterns, beliefs, values, arts, customs, and lifeways, including all other products of human awareness (intercultural, multicultural, cross-cultural sensitivities, etc.) that guide people in their worldview and decision making (Purnell & Paulanka, 1998).

**Culture-Amish:** An ethno-cultural perspective that includes the learned, shared, and transmitted values, beliefs, norms, and life patterns of Amish persons within the boundaries of their religion. “Culture-Amish” explains the origin (the emic-ness) of the Amish world view. These patterns guide thought processes in decision-making as well as behavior patterns and practices (Leininger, 1991).

**Culture Care:** Maintenance of a culture within the framework/theory of Culture Care. The ability to know and understand the culture in question, using that understanding to build a relationship with others and interrelate their culture with care in a sensitive manner. The cultural values and life ways are thus respected and followed as closely as possible utilizing the knowledge gained to intervene with appropriate actions of cultural preservation, maintenance, or development of new patterns of care (Leininger, 1991; Miller, 1997; Wenger, 1988).

**Culturally Congruent Care:** A meaningful fit of culture-care patterns, values, and practices designed to preserve, maintain, or change health or life-care practices for the health benefits and/or satisfaction of clients when mutually agreed upon (Leininger, 1991; Wenger, 1988).

**Ethnography:** A type of inquiry that aims to describe or interpret the place of culture in human affairs. Ethnography is mainly defined by its subject matter or culture, rather than its methodology, which is most often qualitative. Ethnography allows for greater heed to be paid to indigenous knowledge, not only as a means to more fully understand the needs of people and their community, but also as an important source of potential problem-solving for a community’s problems or challenges. It also allows for rich descriptions of data and culture. One quote from Spradley (1970) is worthy of

repetition: “Cultural descriptions can be used to oppress people or set them free” (Spradley, 1970, p. 13; see also, Chambers, 2000).

**Emic:** Explains the local-oriented insider’s view of a culture; a cultural perspective and explanation (Kottak, 2006, pp. 258-259).

**Etic:** Explains the outsider’s knowledge of a culture (Leininger, 1995).

**Ethno-religious:** Explains the religious origin of a culture. Having emic knowledge of the specific meaning, experiences, symbols, or processes within the cultural context of the religion helps one to understand the orientation of the people group studied (Schwartz, 2002). For example, the ethnic origin of the Amish is their religion.

**Health:** Often culturally defined, valued, and practiced as a state of well-being. This usually reflects the individual’s ability to perform activities of daily living within the culture in a way that is beneficial to the accepted norm of life (Leininger, 1991; Reynolds & Leininger, 1993).

**Health Beliefs:** The beliefs inherent within the educational, social, and ethno-religious environment of the Amish community that influence health care values and practices (Schwartz, 2002).

**Model:** A structured concept or framework used to characterize ideas; often used by anthropologists and behavioral scientists to characterize whole societies. It may also be specific precepts constructed by someone interested in conveying important ideas or principles encased in the model (Hostetler, 1993).

**Natural Healer:** One who practices alternative medicine. This may include families who use folk remedies, a chiropractor, herbalist, or acupuncturist. Alternative

medicine is utilized frequently by the Amish and may also include salves, poultices, herbs, supplemental minerals, and vitamins (Schwartz, 2002).

**Ordnung:** Amish expected behaviors; the unwritten blueprint that regulates their private, public, and ceremonial life. The *ordnung* is a code of conduct that the church maintains by tradition and individuals understand and live by. In some areas of life, the *ordnung* is very specific, including items such as the way the Amish dress, or proscriptions as to what technology or décor they may have in their homes. Certain understandings are taken for granted and practiced regarding the (ethno)-history, religious, educational, and social beliefs that Amish culture promotes. The *ordnung* is about living God's way, which is often referred to as the Amish way. A respected *ordnung* brings peace, love, contentment, equality, fellowship, and unity to the family. Following the *ordnung* is about abandoning self and being focused on faith, God's simple ways for healing, submission, and self sacrifice for others in order to be a blessing to them and your community (Kraybill, 1989).

**Participant Observation:** A method of collecting data that relies on listening, watching, and asking questions. A participant-observer elicits from others their definitions of reality and the constructs of their world (Nelson, 1999).

**Principle:** A comprehensive fundamental doctrine or law. A principle can also be described as a rule or code of conduct that encompasses a framework or transcending assumption (Merriam Webster Online Dictionary & Thesaurus, 2005; Dr. Larry Purnell, personal communication, November 23, 2005; Dr. Madeleine Leininger, personal communication, November 25, 2005).

**Risk-Reduction:** The concept of employing on-going risk assessment in the care of patients. One of the hallmarks of a nurse-midwifery practice is the promotion of the health and well-being of the mother and child during the childbearing period within both their family and community (American College of Nurse-Midwives, 2003).

**Servant-Leadership:** Servant-Leadership is best defined by the concept that the leader is always a servant first in this very practical philosophy that encourages trust, collaboration, and the ethical use of empowerment in partnerships (Spears & Lawrence, 2002). Spears and Lawrence (2002) state that many of today's top leadership are thinkers who creatively arrive at ways to write and speak about Servant-Leadership as an emerging model for leadership paradigms of the 21st century.

These ideas are being penned by writers such as (Bennis, 1994; Blanchard & O'Connor, 1997; Covey, 2001; DePree, 1997; Hunter, 1998; Maxwell, 2001; Wheatley, 1999). Cutting-edge leadership authors and advocates of Servant-Leadership believe that it is the essence of quantum thinking and leadership. Greenleaf (1977) gave meaning to the paradoxical term "Servant-Leadership." A careful consideration of Greenleaf's original writings has been the inspiration for the formulation of 10 key characteristics based on Greenleaf's Servant-Leadership theory (Spears & Lawrence, 2002).

### **Methodology**

Culture care is at the core of the Amish worldview and social structure and guides their choices in everyday life (Wenger, 1988). Employing a research methodology that focuses on the culture of the Amish childbearing woman with an effort to understand her worldview is the hallmark of ethnographic research. An ethnographic qualitative approach provides one-on-one interaction with people in their cultural context. The

ethnographic method was used to aid in exploring and describing the health care beliefs and practices of Amish women during childbearing, and the implications for nurse-midwives as servant care providers.

The advantages of utilizing ethnographic research are many. The research is embedded in cultural theory, which is essential to understanding another culture (Leininger, 1991). Leininger proposed that since ethnography is both descriptive in nature and embedded in cultural theory, a researcher is able to find meaning contextually, and the ability for transferability to other settings and disciplines often is possible. Ethnography is interpretive and holistic in that it provides detailed information about a small group of people, and researchers are able to discover information from each participant's experiences and perspectives.

In her research on breast cancer and practices of Amish women, Schwartz (2002) found ethnographic methods provided the best way to gain entry and immersion into the Amish culture. She found that ethnography provided a firsthand opportunity to interact with Amish women. The method opened up opportunities to understand the culture and thereby to find meaning in the context of the culture and enhance the transferability of the method to other settings. Ethnography is designed to assist the researcher in exploring and describing as closely as possible the participant's perspective because the hallmark of ethnography is to inductively and holistically understand human experience (Polit, Beck, & Hungler, 2001).

Polit et al. (2001) state that the aim of the ethnographer is to learn from the cultural group being studied and to obtain the emic perspective—the way the participants envision their world. This is an ethical and holistic method for revealing tacit knowledge.

Ethnography can reveal information that is so deeply embedded in cultural beliefs and practices that the participants may begin to verbalize their unconscious thoughts and open up new ways for them to communicate.

Data were collected using semi-structured interviews comprised of questions guided by a Servant-Leadership model, incorporating the 10 characteristics outlined by Spears and Lawrence (2002). Intense observation and these interview questions were used to elicit information on the topic of childbearing experiences from Amish women. The Amish women involved were encouraged to share their personal experiences about childbearing and their expectations of care providers.

The sampling was purposeful, selecting participants who were knowledgeable about, and have had experiences related to childbearing. Data entry was completed using notes from the field and interviews, transcribed using a word processing program. N-Vivo was a consideration for usage to analyze the data, but Taba was used because it allowed for closer identification with the data. During analysis, themes within the research focus were identified and further analyzed for implications in understanding the health care reasoning and choices of Amish women as they apply to the nurse-midwife as Servant Leader.

### **Summary**

This study aimed to enable care providers to gain insights into the health care beliefs and practices of Amish childbearing women and obtain knowledge as it related to the application of Servant-Leadership principles in teaching and providing health care within the Amish community. Exploring these variables of interest within the context of the Amish woman's personal and cultural beliefs about childbearing afforded various

opportunities for the provision and receipt of better health care. For example, at-risk childbearing Amish women had opportunities to ask questions and share experiences within the educational and social framework of their culture, a setting that decreased misunderstandings and built mutual trust and respect.

### **Organization of the Study**

The dissertation has been organized into five chapters.

Chapter 1 provides the introduction, research background, statement of the problem, purpose of the study, research questions, rationale for the study, theoretical framework, significance of the study, definition of terms, assumptions of the study, general methodology, delimitations and limitations, summary, and organization of the study.

Chapter 2 contains an introduction and review of the literature, identifying the problem and the gaps in the literature. The ethno-culture of Amish childbearing women and the representative literature related to the conceptual framework are discussed. The strategies used for classifying, reading, and critiquing the literature are addressed. The chapter ends with a brief conclusive summary of the chapter highlights and focus.

Chapter 3 describes the methodology, including the purpose and research design, a description of the population and sampling procedures used in the study, a restatement of the problem, and description of the instrumentation, pilot study, and procedures used in the collection, processing, and analysis of data. The chapter concludes with a brief summary of the methodology used for the study.

Chapter 4 is the presentation and analysis of the data, including an introduction, a description of the data, an analysis of the data via the research questions, and a summary.



Chapter 5 provides an overall summary of the study, discussion of the findings and their implications, as well as recommendations for further research.

## CHAPTER 2

### REVIEW OF RELATED LITERATURE

This chapter is organized into three main sections: First, a brief discussion will be presented on culture in general from several different perspectives, followed by an examination of the four components of the Amish culture—the (ethno) historical, religious, educational, and social—and how these cultural beliefs and practices affect childbearing health care for the Amish woman. Second, previous research will be examined relating to the health care beliefs and practices of Amish women and the importance of providing culturally congruent care to this population. Finally, an overview of the body of literature specific to Servant-Leadership will precede a brief conclusive summary of the chapter highlights and focus.

In preparation for research into Amish childbearing beliefs and practices and the implications for Servant-Leader care providers, a review of literature related to these inquiries was conducted. Emphasis was placed on research dissertations, articles, and citations from other printed sources (such as books) related to these subjects. To that end, several databases were searched, including Dissertation Abstracts (Proquest), Cinahl, Medline, Eric, EDUC AB, So Ab, Soc Sci Ab, PsycINFO, Wilson Select, OCLC, EBSCO, JSTOR, Google, Yahoo, and Altavista. The search also included personal communications with Dr. Karon Schwartz and Dr. Steven M. Nolt, both authorities in the field of Amish study. Other personal communications included discussions with Mr.

Larry Spears, Chief Executive Officer of the Greenleaf Center for Servant-Leadership, and Dr. William Mason, whose dissertation was based on his research of Servant-Leadership principles in health care. Further communications included telephone conversations with culture care advocate experts Dr. Madeleine Leininger and Dr. Larry D. Purnell; both have extensive health care experiences in the field of transcultural nursing and have developed culturally competent theory models.

### **Culture**

In this study, the anthropological conception of culture will be used as a workable definition and outline for describing culture in general. Leininger (1970) proposed that both nursing and anthropology support and reinforce each other in that both are holistic and grounded in ethnoscience. Anthropological cultural context knowledge is essential to nurses who are sincere in their efforts to improve client care by understanding holistic cultural factors (the descriptions and analysis of the life practices and the rules of behavior of a given culture). The nursing profession has long supported the concept of holistic or comprehensive client care thus, an anthropological cultural approach affirms the belief that clients have a right to have their cultural needs be recognized. Hall (1959), Hofstede (1991), Peoples and Bailey (2000) as anthropologists gave credence to the concept of culture as a collective whole of ethno-learned knowledge and practices—the norms, values, symbols, classifications of reality, and the worldviews of a set of people. The culture of a group consists of shared, ethno-learned beliefs and practices exemplified in patterns of behavior (Peoples & Bailey, 2000).

Understanding the broad extent to which culture affected the life of Amish childbearing women was an important tenet that touched on the ultimate purpose of this

study. Exploring with the Amish women the meaning of their lived experiences within the context of their culture opened up avenues to gain insight about their health care beliefs and practices. Hall (1976), a leading anthropologist and ethnologist of our era, also supported the theory that culture is more than mere custom that can be shed or changed like clothes; culture is truly communication.

In his first book, *The Silent Language*, Hall (1959) reported that after the Depression anthropologists who had the concept of culture at the heart of their work were able to make some improvements in how dominant societies often treat minority groups. Historically, terrible mistakes were made and have yet to be rectified, including the treatment of the Native Americans in 19th-century North America. This group underwent horrible atrocities as a direct result of the failure on the part of the settlers to try to understand the life and culture of the Native American.

People groups within specific cultures are significantly different from other people groups, and culture controls behaviors in deep and persisting ways, many of which are outside of the individual's awareness and conscious control (Hall, 1959). Understanding another culture will ultimately be rewarding in that it forces one to pay attention to those details of life that differentiate between yourself and members of another culture. The theory of culture as communication examines how the language of culture speaks as clearly as the language itself—culture is about what people do, think, and the hidden rules that govern them. It is the richness of human life and all the meaningful combinations that dictate how life is lived that constitute culture (Hall, 1959).

Culture conditions us to perceive our world in certain ways. All cultures have developed values based on beliefs and models, both formal and informal. Hall (1976), in

his book *Beyond Culture*, promoted that understanding culture must be within the context of breaking the code on all the varying proportions of the meaning of that culture. The code would be incomplete if it encompassed only part of the message. Hofstede (1991) advocated that understanding culture is to understand the source of one's mental programming. This mental programming constitutes the main cultural differences among people groups, namely their values. Culture is learned, not inherited; and the word culture is often used loosely in everyday language to describe concepts which involve collective and shared artifacts, behavioral patterns, beliefs, values, or other concepts. Together, these form the culture as a whole. For example, members of an ethno-religious group are said to share culture, yet at the same time the group also defines culture (Dahl, 2004).

Hofstede (1991) defined culture as a programming of the mind which distinguishes one group or category of people from another. From another perspective, Hall (1984) viewed culture as often being subconscious. The members of a society seem to internalize the cultural components of their society, and then act within the limits of what the society defines as culturally acceptable. Often the lines of acceptability are arbitrary, but culture always dictates where to draw the line separating one concept from another. At that point, the concepts are internalized and lived in the lifeways of a culture's members (Hall, 1984).

Several different conceptual models of culture have been proposed. Culture consists of various factors and levels that are shared by a given group and act as an interpretive frame of behavior for that group (Dahl, 2004). For example, at its most rudimentary, culture is believed to consist of two levels: values and behavior. This model is often referred to as the "iceberg model" of culture (Dahl, 2004). Hofstede (1991), on

the other hand, proposed that culture is a set of four layers that can be peeled like an onion, layer by layer, to reveal the contents.

At the core of Hofstede's model are the values or broad tendencies of a cultural group to prefer certain things over others, the belief of how things ought to be combined with these values make up the innermost hidden layer of culture. Hofstede (1991) advocated that understanding culture requires that one understand the source of one's mental programming. This is what constitutes "values" and is referred to as the secret layer of culture in the onion model. The outer layers, or the three more visible levels of culture, are the rituals, the admired persons who set examples for behavior, and the symbols, words, or other artifacts that carry a special meaning. Hofstede (1991) articulated that these values strongly influence behavior.

Interest in other cultures is as old as time itself. It was not, however, until the 1950s that a structured theoretical approach was derived detailing how to classify and conceptualize cultural patterns. This approach was developed at approximately the same time that Hall's (1959) *Silent Language* was published (Dahl, 2004). Dahl (2004) illustrated how Hall (1959) identified two classic dimensions of culture, the high- and low-context concepts. This classification remains one of the most frequently and easiest to use concepts for examining dimensions of culture. Hall's (1976) theory of Conceptualization of High Context Culture proposed that context and meaning are inextricably bound up with each other and must be studied in relationship to each other.

This theory has been linked together with the transcultural nursing theory, particularly Leininger's theory of cultural care diversity and universality (Wenger, 1988, 1993, 1995). Hall's theory fits with Leininger's theory in that the knowledge of meanings

and practices derived from the culture context are essential to guide nursing decisions and actions in providing culturally congruent care. Leininger (1970), being a nurse anthropologist and grounded in cultural anthropology theory, blended the two worlds of anthropology and nursing together to form the theory of culture care. She believed that people have a right to outsiders understanding their sociocultural backgrounds, which led to the concept of transcultural nursing (Leininger, 1970).

Cultural values, such as beliefs about one's heritage, religious, educational, and social tenets, affect the individual's practices and worldview and can cause conflict when dealing with other people groups and their values (Hofstede, 1991). Exploring the mind-set of the individuals in a culture requires the knowledge that human beings use cultural creativity to construct rich understandings of everyday experiences. Discovery and sharing of aspects of a culture will shed light on how that culture works and provide opportunities for cultural sensitivity (Finn, 1995; Schultz & Lavenda, 1998).

The Amish culture has been explored in this study from the viewpoint of four components that make up the Amish beliefs about life, ethno-history, religion, education, and social activity. These layers of Amish culture are composed more or less of an integrated system of shared beliefs, feelings, and values, and associated patterns of behavior (S. M. Nolt, personal communication, November 18, 2004).

### **The Amish Culture**

Understanding Amish childbearing beliefs and practices requires that one understand the role that Amish culture has played in the development of those beliefs. These culturally cultivated beliefs and practices need to be understood by health care providers seeking to provide health care services to this population (Campanella et al.,

1993; Leininger, 1995; Miller, 1997; Nelson, 1999; Schwartz, 2002; Wenger, 1988; Yoder, 1984). Examining the Amish culture—made up of the ethno-history, religious, educational, and social origins of their culture—gave emic meaning within the cultural context of Amish childbearing beliefs and practices. Leininger and McFarland (2006) state:

Care providers who desire to give culturally based care need to have sensitive and knowledgeable ways to appropriately and meaningfully fit the cultural values, beliefs, and lifeways of clients in order to impact their health and wellbeing, or to prevent illness, disabilities, or death. (p. 15)

Short birth intervals, grand multiparity, increased maternal age during childbearing, consanguinity, increased rate of twinning, a diet high in fats and sugar, obesity, lack of medical insurance, late entry to prenatal care, and distance from health care facilities are just a few of the challenges faced by traditional health care providers working with the Amish (Buccalo, 1997; Campanella et al., 1993; Dellasega et al., 1999; Schwartz, 2002). An understanding from the Amish childbearing woman's emic perspective may give additional insight as to how using a theoretical model such as Servant-Leadership could decrease misunderstandings and better enable care providers to implement culturally sensitive and positive pregnancy outcomes in the face of these challenges.

Leininger and McFarland (2006) proposed that in order to give culturally congruent health care that is meaningful it must be from the informant's perspective of what constitutes culture caring care and based on their cultural orientation. In order to understand the context of Amish culture and its role on the beliefs and practices of Amish childbearing women, the ethno-historical perspective (their heritage) as well as their



ethnic identity (the religious, educational, and social origins of their culture) needs to be considered (Miller, 1997; Nelson, 1999; Schwartz, 2002; Wenger, 1988; Yoder, 1984).

### Ethno-Historical Origins

Research has established that in order to undertake meaningful study within a religious culture it is useful to have historical background information on the beliefs, values, and practices of the people who make up that culture (Hostetler, 1993). Examining the historical origins of a culture provides emic meaning within the cultural contexts of that community's beliefs. Blair and Hurst (1997) maintain that while health care decisions must often be made on rationalistic and economic grounds, these decisions occur within the framework of Amish culture, of which the ethno-history plays a pivotal role. The ethno-history of the Amish includes written documents, oral literature, material culture, and ethnographic data that are pertinent to the Amish people.

One of the most fundamental historical values of Amish culture is captured in the word *Gelassenheit*, which means submission or yielding to a higher authority, namely, God. Obeying God's will in all things is an overarching principle that provides the foundation of the Amish beliefs, lifestyle, and practices (Brende, 1996; Hostetler, 1993; Kreps & Kreps, 1997; Wenger & Wenger, 1998). The Amish place high value on keen observance of the virtues of obedience, humility, and caring. These are also fundamental to their worldview (Hostetler, 1993; Kraybill, 1989; Kraybill & Bowman, 2001).

Hostetler (1993), Huntington (1976); Kraybill (1993); Kraybill and Olshan (1994), Nolt (1992), Schwartz (2002), and Wenger (1988, 1995) have all stressed the manner in which the Amish consistently adhere to old traditions and practices; a set of rules known as the *ordnung*. The *ordnung* consists of an unwritten set of rules embodying

the teachings and practices of the church. These practices have evolved slowly over time and have allowed for gradual and rational changes based on Biblical teachings and principles. These historical values have influenced the health care of the Amish and impact their ethno-religious practices as well.

### Ethno-Religious Origins

From their early history the Amish have been a church-community, usually comprised of 10-15 families per church district. Ethno-religious origins are defined in the context of the Amish practice of simple and austere living. As a conservative branch of Christianity, the Amish are family oriented and follow a labor-intensive economic system that lends support to all members as part of their faith-based beliefs. Their faith and the struggles of their European past shape the Amish life and worldview. They are able to accept and learn from the hardships of the past, using that knowledge to provide a visionary concept for their children's future (Hostetler, 1993; Kraybill, 1993; Nolt, 1992).

As members of the early Germanic settlement of Pennsylvania, the Amish religion originated in the Anabaptist movement (Hostetler, 1993). Hostetler (1993) stated that all Anabaptist groups suffered martyrdom for their deviation from established religions such as the Catholic, Lutheran, and Reformed churches. The mission of the church lies in the understanding of maintaining a redemptive community (Hostetler, 1993). Twice each year before the observance of the Lord's Supper, the members declare their personal peace and unity with others and affirm anew their beliefs. Discipline for violation of the beliefs varies with the seriousness of the offense; failure to acknowledge wrongdoing may result in temporary withdrawal of church privileges.

The Amish hold that membership in the Christian church should be voluntary, that church and state should be separate, and that believers should be allowed to practice the teachings and follow the example of Christ in disciplined communities of their own choosing (Hostetler, 1993). The Amish, however, do not emphasize individualistic conversion to the exclusion of community; adult baptism is practiced once the young person is ready to submit to the concept of repentance and commit to the believing community and its discipline. The Amish stress cross-bearing and suffering rather than self-gratification, hope rather than assurance, a submissive attitude rather than a subjective experience, and a silent rather than outspoken testimony or verbal expression of faith (Cronk, 1989; Kraybill & Olshan, 1994).

Amish parents strongly believe in exercising patience with their young during the formative years, believing that patience, manual work, and a strong family will ultimately foster in the child a desire to be a steadfast member of the community and church. Hostetler (1993) believed that this form of persuasion, rather than the use of authority to coerce compliance, encourages life-long commitment to the Amish religion. Strong value is placed on obedience, humility, and caring for others. It is within this ethno-religious framework that Amish women participate in the joy of birthing anticipation.

Hostetler (1993) advocates support for the Amish women's admiration for creation, respect for nature and order, and practice of personal rather than impersonal relationships in a world where community and human contact often are not valued. The educational training of young Amish children incorporates these ethno-religious beliefs into the curriculum to form a strong foundation that is supportive of Amish culture.

### Ethno-Educational Origins

The Amish view true education as the cultivation of humility, simple living, and resignation to the will of God. Ethno-educational origins are defined by the ongoing commitment to the growth of others for the good of the community. These principles are taught early through educational practices in the school, church, and home environment (Hostetler, 1993). Worldly philosophies such as self-exaltation, pride of position, arts of war and violence, and enjoyment of power are not embraced. Listening and empathy for others are highly valued, as is the ability to view and be aware of situations from an integrated holistic position in order to maintain inner serenity (Fisher & Stahl, 1997).

Most Amish children attend Amish schools where it is expected that they will complete Grade 8. The children learn English, reading, grammar, spelling, penmanship, and arithmetic. The Amish are opposed to accepting government subsidies for any type of school support; each school is administered by an Amish school board with careful attendance records kept for state inspection. Amish committees also assist in the selection of the books, which are chosen for their focus on community values (Hostetler, 1993; Huntington, 1976). The school helps the child to become part of their community and to value shared knowledge and the dignity of tradition (Hostetler, 1993; Huntington, 1976; Kraybill, 1993; Kraybill & Bowman, 2001; Langin, 1994). The curriculum, in conjunction with framed mottoes on the walls of the schoolhouse, stresses honesty, thrift, purity, love, and cooperation. Older children assist the younger, and pupils are encouraged to help each other strive towards good performance so that the whole class may succeed scholastically (Kraybill, 1989; Meyers, 1994).

The Amish school supports the values taught in the family and in the church. Religion is not taught as a separate subject, but the children are taught a great deal about living their religion. The parents teach religion at home, but do not provide instruction in religion to the children of other Amish families. Personal relationships between teacher and pupils, as well as between pupils and their classmates, are considered necessary preparation for life both now and for eternity (Fisher & Stahl, 1997; Hostetler, 1993; O'Neil, 1997).

Hostetler (1993) stated that textbooks in Amish schools are, for the most part, outdated textbooks that public schools have discarded and are used by the Amish schools because they align more closely with Amish beliefs. This practice allows for the purposeful exclusion of the self-centered and evolutionary thinking that the Amish believe comes from modern thinking and science. The value of education is seen in the dedication of the Amish teachers, who uphold the Amish way of life, and in the apprenticeship that all children complete with their families after the eighth grade. The apprenticeship allows children to learn a trade by practical application. This learning experience is viewed by the Amish as being as important as most Western cultures view a college degree (Hostetler, 1993; Kraybill, 1993).

The Amish maintain a cultural boundary between themselves and the outside world (Wenger & Wenger, 1998). This boundary protection is taught and reinforced by the parents and the teachers throughout the educational process. These ethno-educational factors later influence how Amish adults make decisions to incorporate or not the usage of high-tech and modern medicine. The Amish bishops are instrumental in protecting the cultural boundaries of their communities. They decide if a particular medical technology

threatens the values or traditions of the Amish community and will ban a procedure that threatens these beliefs. This understanding is important for the childbearing health care provider to be aware of when offering prenatal care that encourages high-cost technology, mandatory screening, or invasive procedures that are not viewed as necessary or even understood from an educational standpoint (Campanella et al., 1993; Kraybill, 1998; Wenger, 1988; Yoder, 1997).

### Ethno-Social Origins

Ethno-social origins could best be defined as the way in which the Amish family lives within the church community- a way of life in which the ethical teachings of Jesus are practiced. One of the most important pinnacles of the Amish worldview is the value that child rearing holds in the social conscience of the Amish family. Child rearing is the most important activity an Amish couple will undertake (Hostetler, 1993). Marriage is regarded highly and is considered a single unit dissolved only by death. The birth of a child is a very special event and brings much joy to the family and community.

The Amish family is where religious training occurs, and the children are socialized into the Amish way of life. Gatherings around the family table are very important routines in the home; silent prayers with bowed heads before and after a meal are generally the rule. Around the table, joy of good food and the topics of conversation set the tone for work and motivation. Values are shared and the norms of behavior are passed on (Hostetler, 1993; Kraybill, 1998).

The Amish childbearing woman often will bring younger children to prenatal care visits if she is utilizing community resources. If a care provider goes to the home, they also are likely to interact with young children. Therefore it is important for the health care

provider to know that the younger children may not speak English unless they have started school (Hostetler, 1993). Religious training does not include any form of health teaching; this instruction is purposely left to the family. Health care beliefs and practices are learned at the home and from close family members, usually the mother.

Home is the center of life, a place of security for all the family members, including the older, retired members. A smaller “grandpa house” is usually right on the property and is a deliberate move an older couple makes once a married son or daughter takes over the main farmhouse. By providing farmland for their children, the older couple will enhance their standing in the community. The aged parents work as their health and other conditions permit, are not isolated, and are highly respected in the community and their family. This is a very important part of stewardship—holding something in trust for the younger and older members of society and family (Armstrong & Feldman, 1986; Hostetler, 1993).

The Amish have many social bonds in addition to their personal commitment to the faith. They believe commitment is about self-sacrifice, submission, obedience, right living, and demonstrating care both to God and one's fellow man. The concepts of right living are also perceived as living a simple lifestyle that includes homeopathic and natural means as the first-choice method for prevention or healing of injury or disease. This concept has important considerations for the health care provider who desires to be sensitive to Amish women's health care beliefs (Schwartz, 2002).

Community cohesion is supported by the way the past is incorporated into the present, providing hope for the future. Most Amish speak three distinctive tongues. The household speech is generally a dialect called Pennsylvania German or Pennsylvania

Dutch (a.k.a. German). The second language is English, usually introduced when the children start school. The third is a passive knowledge of High German, learned through the reading of the Bible and recitation. Sermons and formal ceremonies usually are conducted in High German. The Amish will shift conversation between dialects, using whichever is more appropriate to the occasion (Hostetler, 1993; Wenger, 1970).

Hostetler (1993) stated he often is amazed at the bilingual competency and adaptability that the Amish first exhibit at an early age. This ability to converse fluently in at least two languages is particularly important for women, since often the health care needs of Amish childbearing women force them to go outside their culture for assistance (Wenger, 1970).

#### Health Care Beliefs and Practices of Amish Women

Yoder (1984) noted that Amish women obtain their health knowledge from testimonials of other persons and formulas handed down from generation to generation; knowledge usually is gained primarily from their mother. Some Amish publications do provide health instruction and intervention information, mostly from a natural remedy perspective. Indigenous practitioners such as naturopaths, Brauche (sympathy healers), chiropractors, and Amish lay practitioners often are sought out for treatments. It is not uncommon for the Amish population to utilize both indigenous and modern medical practitioners at the same time (Palmer, 1992; Weyer et al., 2003). Yoder (1984) and Schwartz (2002) maintained that Amish women desire a nurse practitioner who exudes warmth, caring, and sensitivity for Amish beliefs first and foremost. Technical skill and competency are taken for granted, as Amish women seek a basis for trust beyond demonstrated scientific knowledge.



Schwartz (2002), in her professional symposium and presentation of her research findings, encouraged future researchers not to be intimidated by the prospects of Amish women being reluctant to talk about personal matters. The women in her study were very willing to share information that was viewed as helping others. The studies available on Amish women have indicated a need for further research from the Amish woman's perspective in order to provide culturally congruent health care that is meaningful for the Amish childbearing woman (Campanella et al., 1993; Leininger, 1995; Miller, 1997; Nelson, 1999; Schwartz, 2002; Wenger, 1988; Yoder, 1984).

Research topics such as how to deliver culture-sensitive and caring childbearing health care from the Amish woman's perspective need further exploration. The transferability of the findings would provide useful information to help educate health care providers and the Amish population on effective partnerships that reduce health risks. Utilizing Servant-Leadership attributes for achieving congruent culture care in a mutually beneficial partnership was reviewed in the literature, as demonstrated later in this chapter within the discussion of the Servant-Leadership model.

### **Culturally Sensitive Health Care**

The term “cultural competence” denotes a relatively new concept to most academic disciplines (Shen, 2004). Anthropologists who were concerned with ethnographic descriptors of cultural groups have used tools for addressing cultural competence. Most of these, according to the literature, were not specifically designed for nurses and are too detailed for use with individual clients in a health care setting.

Since its widespread inception in the 1980s, cultural competence has become more prevalent in the field of nursing research and study. Shen (2004) expounded on the

major cultural competence models that are available in nursing, including contributions by Leininger (1991), Campinha-Bacote (2003), Giger and Davidhizar (2004), Orque (1983), Purnell and Paulanka (2003), Spector (2004), and Andrews and Boyle (2002). There is general agreement on the definition of “cultural competence” or “culturally congruent care.” To be culturally competent, nurses need to be able to assess and understand culture and use their skill and knowledge in creative ways, particularly with people of diverse worldviews. Providing culturally sensitive care requires a diversity of thinking based on a broad multicultural worldview (Purnell & Paulanka, 1998). Purnell and Paulanka (1998) advocated that culture—which is the totality of transmitted behavioral patterns, art, belief, values, lifeways, and all the products of human working characteristics that guide an individual’s worldview and decision making—must be understood in order to develop mutually satisfying relationships with those of another culture. Dobson (1991) affirmed the importance of having a basic understanding of culture to give culturally sensitive health care.

Culture needs to be defined by describing the way of life, tenets of cultural acceptable beliefs and practices, and the vision of the person or of society. Hence, when promoting health, it is important that nurses consider the wider cultural definition as it relates to the client’s everyday world. Planning and provision of care need to be congruent with the client’s culture and understanding. This crossing, spanning, or interacting with another culture in nursing care is known as “transcultural nursing” (Dobson, 1991; Purnell & Paulanka, 1998). Leininger (2002) further bridged the gap between defining transcultural care and cross-cultural care. The term “cross-cultural”

comes from the discipline of anthropology and is defined as focusing on the study of diverse cultures in different geographic places.

The term “transcultural nursing” was coined in the 1960s and required a theoretical framework or model that was culture care specific and transcended cultural boundaries. Most nursing researchers generally make no distinction between a model and a framework and use them interchangeably. A culturally competent framework would be used as a culturally competent model (Shen, 2004). Transcultural nursing involves holistic-particularistic care with conceptual and practice goals that provide culturally congruent and responsible care to a people group outside of your own (Leininger, 2002).

Brink (1999) agreed that the word “transcultural” refers to concepts that transcend culture and are universal. All cultures have these broad concepts. In comparison, the concept of cross-cultural takes into consideration that cross-cultural studies will look for contrasts, similarities, and comparisons across other culture groups as a case study, such that cross-cultural data will yield transcultural concepts. She further defined “intracultural” as being within a single culture.

During the last three decades, transcultural nursing research has shown that individuals, families, and groups possess deeply held beliefs and practices within their culture that impact upon their well-being (Leininger, 1985, 1991, 1995; Wenger, 1988; Yoder, 1984). Dobson (1991) stated that using the same language and understanding when describing the ethno-heritage (history) and ethnic identity (religious, educational, and social) is an important principle when seeking insight and understanding about the culture of a group.

Our world is changing and, with the global cultural changes, new expectations and challenges are crucial for nurses to become competent and sensitive as they care for people of diverse cultures in the world (Giger & Davidhizar, 2004; Leininger, 1970, 1991, 1995, 2002; Purnell & Paulanka, 2003). Transcultural nursing is built on a scientifically sound and humanistic base of research, providing an important way for nurses to meet their client's holistic cultural needs. Nurses cannot afford to be either ignorant or complacent regarding the cultural needs of those they serve (Leininger, 1995). Culturally based care knowledge was the major missing area in nursing during the mid-20th century, until Leininger, as a nurse and anthropologist, coined the construct "culturally congruent care." Nurses needed in-depth information and theory with an anthropological view and culturally based care model.

The importance of transcultural nursing is particularly relevant in this era of globalization that links nursing with the world through health care. Nurses come in contact with many diverse cultures and are linked together in order to provide competent care to many cultures. However, several ethical and moral problems have arisen due to cultural value conflicts, resulting in culture pain. Meaningful data are needed to understand humanistic and culturally based nursing care in order to give new insights and prevent cultural clashes and pain. Providing culturally congruent, sensitive, and responsible care must be a high priority for health care providers, creating a significant demand for necessary reforms in education and service settings (Giger & Davidhizar, 2004; Leininger, 1995; Purnell & Paulanka, 2003).

Overall, five tenets need to be considered when providing a culturally congruent model for assessment within nursing practice. First, culturally based care must be the

essence and unifying focus of the model. Second, culturally based caring is essential for well-being, health, growth, and survival; this must be kept in mind at all times. Third, culturally based care is the most comprehensive and holistic means to know, interpret, and explain the beneficial congruent care practices. Fourth, culturally based care is essential to healing and promotion of client-sensitive interventions. Fifth, the meanings, patterns, and expressions of culture care concepts will vary transculturally (Leininger, 2002).

There are several helpful culturally competent models in the nursing literature. Three of these models held particular significance when conceptualizing constructs that would be helpful when working with Amish women: the Sunrise Model, Purnell's model for cultural competence, and Giger and Davidhizar's transcultural assessment model. These models will be discussed in more detail in the Servant-Leadership model section.

The Sunrise Model by Leininger (1985) is a visual model that provides a holistic conceptualization and allows for interrelated cultural care dimensions (worldview, social structure factors, values, and incorporation of folk and professional health systems) to be assessed within the cultural confines of a people group. The model has been used to assess cultures and explore their hidden secrets about human care and health. Uncovering these embedded ideas and largely unknown areas in nursing from a comparative viewpoint is why transcultural nursing has become a focused and formal area of study.

According to Burchum (2002), it is conceptual attributes rather than definitions that provide the foundation of any cultural competence model. Cultural competence is a nonlinear and expansive process that implements attributes to compose the process of being culturally sensitive. In summary, it is the ongoing knowledge and skill that is

developed by employing the attributes of cultural competence to health care that will assist in the delivery of culturally sensitive care to different social groups (Burchum, 2002; Giger & Davidhouser, 2004; Leininger, 2002; Purnell, 1999).

### **Provision of Culturally Congruent Care to the Amish**

There are five significant dissertations on providing culturally congruent care to the Amish: Schwartz (2002), *Breast Cancer and Health Care Beliefs, Values, and Practices of Amish Women*; Wenger (1988), *The Phenomenon of Care in a High Context Culture: The Old Order Amish*; Yoder (1984), *Influence of Cognitive Style on an American Subculture's Health Seeking Behavior and View of Nurses*; Nelson (1999), *A Study of Amish Women's Construction of Health Narratives*; and Miller (1997), *Childbearing Health Practices as Described by Old Order Amish Women*.

Care is the pivotal and central theme for nursing theory and research (Leininger, 2002). These seminal studies on the Amish focused on health care and caring in the Amish culture, describing the importance of care providers who want to provide culturally sensitive care being understanding and knowledgeable of Amish beliefs and practices, particularly when providing education, health care, or conducting research (Giger & Davidhouser, 2004; Leininger, 2002; Purnell, 1999). These five studies identified the necessity to preserve and maintain as much of the Amish culture as possible when working with Amish women. Seeking to understand, maintain, and accommodate the Amish beliefs and practices built trust between the Amish and their care providers. Analyzing what constitutes culturally congruent health care from the Amish woman's context informed health care providers and researchers of potentially sensitive issues in the hope of preventing misunderstandings (Table 1).

One of the most important contributions of these studies was the determination of the importance of health providers giving culturally congruent care when seeking to implement caring interventions. In order to provide culturally congruent care from the emic perspective, the care provider must become knowledgeable of the Amish culture. Further research was suggested to contribute to the knowledge base of research on Amish women's own perceptions of interaction with a non-Amish health system. Speaking directly with the Amish women and listening as they shared about their lifeways was one of the best ways to accomplish this.

The Amish women were willing to share information if approached in a respectful and polite manner, and with sensitivity for their beliefs. They expressed their appreciation for any type of health care that would complement their cultural practices. Certain characteristics were viewed by the Amish informants as demonstrating a caring presence by the health care provider. Those mentioned most often were listening (engaging with presence), awareness (being mindful of their lifeways and concerns), healing (striving to understand and provide holistic healing partnerships), empathy (acceptance and understanding for Amish ways), persuasion (building consensus by creating an atmosphere of trust), conceptualizing (incorporating practices congruent with Amish ways), foresight (having an attitude of service based on discernment and intuitiveness of Amish ways), commitment (demonstrating responsibility for others), and building community (by having a presence that offers compassionate care that is nurturing and open) (Miller, 1997; Nelson, 1999; Schwartz, 2002; Wenger, 1988; Yoder, 1984).

Table 1

*Synopsis of Significant Cultural Studies on the Amish*

Study	Synopsis
Schwartz (2002) <i>Breast Cancer Health Care Beliefs, Values, and Practices of Amish Women</i>	<p><b>Objectives:</b> To characterize the breast health and cancer knowledge, beliefs, values, and practices of Amish women within the context of their religious and socio-cultural environment and gain an understanding of the health care reasoning and choices of Amish women due to their separateness from society at large.</p> <p><b>Methods:</b> Ethnographic qualitative research was used for interviews of 16 Old Order Amish women. Subjects, between 23 and 62 years of age, were interviewed from their perspective about breast cancer experiences, either personal (<math>n=9</math>) or observed in a close relative. The Health Belief Model and the Illness Behavior Model were used as conceptual models to guide open-ended questions and observations.</p> <p><b>Results:</b> Amish women believe that God's will pervades all things; natural treatments are "God's way" and the first preference. However, with breast cancer both natural and medical treatments are employed. Mistrust with traditional medicine led to seeking medical care as a last resort indicating that lack of communication and understanding between the Amish and the medical community create significant barriers to meaningful health care.</p> <p>The nurse as a health care professional was generally accepted more easily than other health care workers. The role of the nurse as a health care provider is important from the perspective of the Amish woman: a nurse must demonstrate certain characteristics in order to build trust and give culturally congruent care to this population. These characteristics include listening, being aware of and supporting as many of the Amish religious beliefs and values from a non-critical stance as is possible and/or safe for the patient, and demonstrating sensitivity by gently persuading and creating an atmosphere of trust rather than coercing their patient. The Amish women were open to suggestions by nurses especially who were willing to take time to give culturally congruent care. Educational endeavors should first and foremost be considerate of the ethno-cultural beliefs and practices of the Amish women. Future research was suggested to see if transferability of the findings of this study would be meaningful to other Amish health care needs such as childbearing.</p>
Nelson (1999) <i>Construction of Health Narrative</i>	<p><b>Objectives:</b> The goal of this study was to explore the health narrative or life story of selected Amish women and a nurse midwife who had contact with them. The study also explored how Amish women describe and construct health narrative and exchange information with other culture groups.</p>



Table 1—*Continued.*

Study	Synopsis
Nelson (1999), <i>cont.</i>	<p><b>Methods:</b> Health data were gathered from the viewpoint of the women themselves using a qualitative exploratory study design. The sample included 4 women: 1 Amish midwife, 1 Amish pregnant woman, one Mennonite midwife, and one certified nurse midwife were interviewed.</p> <p><b>Results:</b> The study revealed that Amish women rely on their own health traditions and sought assistance from non-Amish health care professionals. This study also revealed that Amish women do interact with non-Amish health care providers in several settings. The health care personnel were perceived by the Amish women as being insensitive to their needs by speaking in a hurried and rapid demeaning manner and used medical terminology and offered them little time for clarification. English is not the primary language, and when technology terms were used the terms were not always understood, valued, or accepted as the best care modality. Herbal, vitamin, and food supplements and home remedies are important health traditions. Healing from a holistic approach includes caring characteristics such as listening, being aware of health care expectations. Health care professionals are often chosen based on what other Amish women have said about them. If they were understanding, empathetic, and holistic in their approach to care they were viewed more positively. Health narratives were influenced by family beliefs and practices and cultural values. The Amish women voiced appreciation in a care giver who listens and cares about arriving at a mutually satisfactory decision about wishes and goals for a care plan. The Amish woman's narrative provided valuable information that can provide wisdom, counsel, and understanding for a non-Amish health care provider who seeks to give culturally congruent care.</p>
Miller (1997) <i>Childbearing Health Practices as Described by Old Order Amish Women</i>	<p><b>Objectives:</b> There is minimal information available on childbearing practices of Old Order Amish women. This was identified as a problem for health care providers who desire to give culturally sensitive care to Amish women.</p> <p><b>Methods:</b> This qualitative descriptive study indicated a need for more qualitative research on childbearing health practices directly from the Amish women's perspective in order to give culturally congruent care. Five Amish women who had experienced four to six pregnancies and anticipated future pregnancies were interviewed in a focus group. Leininger's Cultural Care Diversity and Universality theory with the Sunrise Model provided conceptual framework of the study; the seven fanned sections of the Sunrise model were used to organize the 13 interview questions.</p>

Table 1—*Continued.*

Study	Synopsis
Miller (1997), <i>cont.</i>	<p><b>Objectives and Methods:</b> Broad and open-ended questions were asked that focused on feelings and experiences the women had about their first menses and pregnancy, their understanding of childbearing, and how their faith guided decisions for childbearing. Specific care practices that the Amish women employed for themselves and their baby, and the role the family plays in childbearing also were assessed.</p> <p><b>Results:</b> This study revealed that faith strongly motivates Amish women to bear children. Childbearing is very private and women preferred to give birth in the home. Formal knowledge about childbearing was limited; most childbearing knowledge was passed down from family. Non-Amish care providers were sought only if a complication arose. Amish women who trusted their non-Amish care provider were open to learning. Providing education that is at the Amish woman's level of understanding was important to ensure successful outcomes. Negotiation that was mutual and based on a caring, listening, and empathetic model that built consensus and trust was the most effective technique. Reprimanding for noncompliance or trying to force change was counterproductive. Awareness and discernment were the best methods for incorporating Amish practices into the childbearing care and was the most supportive way to give culturally congruent care.</p> <p>Understanding the Amish culture was essential for a non-Amish care provider who faced the challenge of becoming a trusted partner in the Amish woman's childbearing care. Future research was suggested that would incorporate a larger sample and include older, more experienced Amish childbearing women to compare and contrast childbearing health practices as well as the usage of a one-on-one interview methodology.</p>
Wenger (1988) <i>The Phenomenon of Care in a High Context Culture: The Old Order Amish</i>	<p><b>Objectives:</b> This study sought to discover the meanings, expressions, and functions of care within the context of the culture of Old Order Amish. The study utilized Leininger's Culture Care theory and Hall's concept of high context culture theory. Nurses and other care providers who are outside the Amish culture need research-based knowledge about care meanings and functions in order to provide culture congruent care. This is especially true in cultures such as the Amish who have a high context culture (are deeply involved with each other, and share much contextual knowledge and experiences so that lifeways are preserved in such a manner that is often not understood by others).</p> <p><b>Methods:</b> Ethnography and ethno-nursing research methodology were used.</p>

Table 1—*Continued.*

Study	Synopsis
Wenger (1988), <i>cont.</i>	<p>A total of 13 key informants (mothers of the school children) and 23 general informants who lived near an Old Order Amish school were interviewed.</p> <p><b>Results:</b> Four major themes were extracted from the data. First, culture care is at the core of the Amish culture. Second and third, the Amish actively participate in care actions and anticipate what the family and community needs are for well-being. Fourth, care decisions are a matter of principle and guide choices every day (principled pragmatism). These principles of care were found to be of high importance to the Amish. Some of the attributes of care were defined by the Amish informants as nurturing others, listening, not ignoring but being aware, helping generously by conceptualizing what others need, helping others to achieve wholeness and health, considering the needs of others by stewardship and building community, and putting others above one's self (servant-caring). Health decisions were made from a pragmatic view; if health care providers are viewed as knowing what they are doing and professional care was deemed necessary, then the information and care were valued. There was a negative connotation of high technology and high cost. Fees for professional care often did not seem to correlate with outcome; well-being was not achieved from the Amish perspective. Nurses' teaching roles were recognized as being helpful, with personalized care, visiting, listening, health care instruction, and sensing what is needed by a caring nurse being highly valued. Further research was suggested as needed to validate and clarify that the same themes were applicable in other Amish communities.</p>
Yoder (1984) <i>Influence of Cognitive Style on an American Subculture's Health Seeking Behavior and View of Nurses</i>	<p><b>Objectives:</b> The influence of cognitive style and what impact that may have on care practices had not previously been studied for any age cohort among the Old Order Amish. The advent of the independent nurse practitioner has stimulated interest in understanding how client expectations of them affect care.</p> <p><b>Methods:</b> Twenty-three Old Order Amish and Twenty-three non-Amish persons &gt;60 years of age who lived in a rural area agreed to participate in the study. This study examined four main variables: the ethnicity factor between Old Order Amish and non-Amish, cognitive style (field dependence and field independence), health seeking behavior, and characteristics desired in the nurse practitioner.</p> <p><b>Results:</b> Of seven directional hypotheses proposed in this study, only two were statistically significant. Old Order Amish, more than non-Amish, preferred indigenous rather than modern health services; Old Order Amish, more than non-Amish, desired affective instead of technical characteristics in the nurse practitioner.</p>

Table 1—*Continued*.

Study	Synopsis
Yoder (1984), <i>cont.</i>	<p><b>Results (<i>continued</i>):</b> The Old Order Amish took technical skill and competency for granted but health providers' attitudes and mannerisms were scrutinized for signs of integrity, sympathy, empathy, listening with presence, concerns for holistic healing through indigenous practices, awareness and caring towards their clients. Both the preference for indigenous folk medicine and the preferred affective characteristics for nurse practitioners who desire to provide culturally congruent care to the Old Order Amish are important considerations when proposing meaningful health care.</p> <p>Further research that compares the findings of the characteristics desired in the nurse practitioner with versions of what the sample liked and did not like in nurses who have cared for them was recommended.</p>

These five studies provided an understanding on ways to serve Amish women from an emic perspective and gave impetus and validation for further exploration through research of the characteristics the Amish desire in their health care providers. Health Care Providers also should be looking for methods to serve others in ways that are meaningful to them. Servant-Leadership is about getting people to a higher level by looking for principles and philosophies that are effective in their sphere of culture (Greenleaf, 1977). Exploring the beliefs and practices of Amish childbearing women through the lens of Servant-Leadership principles may provide an opportunity to examine the emic perspective of the participants as it aligns with their culture and a perspective not found in the literature.

### Servant-Leadership

Greenleaf (1977) coined the term “Servant-Leadership” in his essay *The Servant as Leader*. He was a lifelong proponent of stimulating thought and actions to build a

better, more caring society based on the principles of being a servant first as you lead others. The concept grew out of a story he had read in the 1960s about a group of people on a spiritual journey—Hesse's (1956) short novel, *Journey to the East*. The central hero in the story was a person named Leo who disappears, only to be found many years later in a religious order. The narrator of the story finds Leo and comes to the realization that Leo was the great Servant-Leader, who humbly cared for all their needs during the journey and had exemplified the principles of Servant-Leadership.

Greenleaf (1977) concluded that the story purported a great leader must first be a servant to others and be motivated by a caring desire to help others and see them grow. The phrase Servant-Leadership must be viewed with servant or service as the subject and leader/leadership as the predicate. An application of the philosophy of service to the practice of leadership means recognizing the tremendous responsibility to do everything within your power to nurture the personal, professional, and spiritual growth of those you are seeking to serve.

Igou (1999) refers to the value of serving others as being an important concept that the Amish believe and practice in his book *The Amish in Their Own Words*. The role of serving from a Servant-Leadership framework is the key focus, not leadership. The leadership role is only the mechanism used to demonstrate caring and service. This caring is best communicated if the one being served also is personally involved in the understanding. Greenleaf (1977) states:

The servant-leader is servant first. It begins with the natural feeling that one wants to serve. Then conscious choice brings one to aspire to lead. The best test is: do those served grow as persons; do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants? And, what is the effect on the least privileged in society; will they benefit, or, at least, not be further deprived? (pp. 13-14)

Over a period of 20-some years, Greenleaf wrote a series of highly influential essays and books which have pioneered the emerging model of Servant-Leadership that is so popular today. This emergence can easily be seen across the course of major events in his life and career (Table 2). Three posthumous collections also have given hope and inspiration for 21<sup>st</sup>-century practitioners of Servant-Leadership.

Franker and Spears (1996) edited *On Becoming a Servant-Leader* in which Greenleaf reveals the transformation that his thinking went through over 50 years of applying Servant-Leadership principles. The companion book, *Seeker and Servant*, edited by Franker and Spears (1996), illustrates through a collection of more than 90 essays, articles, and papers published for the first time, the importance of the researcher (seeker) having the gift of the appropriate language. There is an existing language, according to Greenleaf, that will provide a common ground in cultures if the seeker will persevere in finding ways to communicate (Franker & Spears, 1996).

Greenleaf's personal experiences and writings helped launch a quiet revolution in the way people and organizations worldwide view and practice leadership. Mr. Spears (Spears & Lawrence, 2002) speaks from his position as the Chief Executive Officer of the Robert K. Greenleaf Center and personal friend of the late Robert Greenleaf. He describes how, three decades after publication, Greenleaf's (1977) famed definition from his book, *Servant Leadership: A Journey into the Nature of Legitimate Power and Greatness*, continues to attract people and organizations away from autocratic and hierarchical models of leadership towards Servant-Leadership.

Table 2

*Major Events in the Life and Career of Robert K. Greenleaf*

Date	Events and Publications
1904	Born on July 14 in Terre Haute, Indiana
1918	Graduated from Terre Haute High School
1922-1923	Student at Rose Polytechnic Institute, Terre Haute  During a Student Volunteer Conference in Indianapolis Greenleaf determined he was no longer interested in engineering so he withdrew from the school during the beginning of his second year.
1924-1926	Enrolled at Carleton College, Northfield, MN  In his senior year, Greenleaf was influenced by his sociology professor, Dr. Oscar Helming to get inside a large institution and work at making the institution more responsive to serving the good of the public. This was the beginning of a challenge that changed his life.
1926-1929	Employee of Ohio Bell, a division of AT&T. Greenleaf began work digging post holes and moved to a position in the plant engineer's office in Akron. He then was trained to lead foreman conferences. He began to think of himself as a student of organization. He then was made Supervisor of Technical Training for the Cleveland office where he developed a method of teaching algebra to those with limited math skills.
1929-1941	Greenleaf moved to New York as the AT&T Department Head of Operations and Engineering. He married Esther Hargrave in 1931, and took a leave of absence from his job in 1934 to visit Denmark and Sweden, where his interest in the Folk High Schools was sparked, later strongly influencing his writing of <i>The Servant as Leader</i> .
1941-1950	Greenleaf moved with the family to New Jersey to become Head of Management, Development Section at AT&T. He helped organize the Central Good Neighbor Committee, Inc., of the State University of New York, to promote education for citizenship. During this time, Greenleaf cited two articles that impacted his life and work; ideas of preparing for a useful old age and being a person of integrity were catalysts for his major work at AT&T.
1950-1957	Greenleaf was a faculty member of the Graduate School of Credit and Financial Management at Dartmouth College. He also was involved with the Laymen's Movement, an involvement eventually leading to the development of a course on Receptive Listening, which in turn became a major program of the Wainwright House Center for Development of Human Potential.

Table 2—Continued.

Date	Events and Publications
1957-1964	Director of Management Research at AT&T. He also was a trustee of the Russell Sage Foundation of New York which supports work in the social sciences, and was a visiting lecturer at both Harvard Business School and MIT. Greenleaf also served as a consultant to the Ford Foundation and as a consultant for a project sponsored by the Lilly Endowment for the National Council of Churches. In 1964, he took a leave of absence to travel to India as a consultant for the Ford Foundation's South Asia Program and helped to reorganize the first school of Administration after India's independence. It was during this time that Greenleaf read Hermann Hesse's <i>Journey to the East</i> .
1964	Greenleaf retired from AT&T after 38 years of service and founded the Center for Applied Ethics, later to be called the Robert K. Greenleaf Center.
1965-1970	He continued to be active in consulting, lecturing, and writing. He also made five trips to India during this time period.
1970	Publication of <i>The Servant as Leader</i> , revised in 1973
1972	Publication of <i>Institution as Servant</i>
1974	Publication of <i>Trustees as Servants</i> , revised in 1975
1975	Publication of <i>Advices to Servants</i>
1977	Publication of his first book, <i>Servant Leadership: A Journey into the Nature of Legitimate Power and Greatness</i>
1979	Publication of his second book, <i>Teacher as Servant: Retrospect and Prospect</i>
1982	Publication of <i>As Religious Leader</i>
1983	Publication of <i>Seminary as Servant</i>
1986	Publication of <i>Life's Choices and Markers</i> , a commencement address delivered at Alverno College
1987	Publication of <i>My Debt to E.B. White</i>
1987	Publication of <i>Old Age: The Ultimate Test of Spirit</i>
1990	Died in September of 1990, the direct author of two books and many essays and other published articles and lectures. His books also include three posthumous collections: <i>The Power of Servant-Leadership</i> (1998), <i>On Becoming a Servant-Leader</i> (1996), and <i>Seeker and Servant</i> (1996).

*Note.* From the Timeline and Chronology Archives, Robert K. Greenleaf Center for Servant-Leadership, Indianapolis, IN.



Involving others in decision-making is strongly encouraged as part of the ethical and caring behaviors that form Servant-Leadership principles. These principles enhance the personal growth of others while improving the caring and quality of the organizational life (Frick, 2004). Today, many creative thinkers are writing and speaking about Servant Leadership as the most important leadership paradigm (Spears & Lawrence, 2002).

### **The Servant-Leadership Model**

A careful consideration of Greenleaf's original writings provided the inspiration for Larry Spears' outline of 10 characteristics that involve a deep understanding and meaningful practice of Servant-Leadership. These 10 characteristics were embedded in Greenleaf's (1977) Servant-Leader principles that, when applied in a meaningful context, have been shown to build trust in relationships and business partnerships (Spears & Lawrence, 2002).

The 10 characteristics—listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of people, and building community—make up the Servant-Leadership model used in this study. Spears proposed that the 10 characteristics of Servant-Leadership extrapolated from Robert K. Greenleaf's writings contributes to the meaningful practice of Servant-Leadership. He expressed a likely connection between Servant-Leadership principles and the cultural beliefs and practices of Amish childbearing women due to the fact that Robert Greenleaf's religious tenets are congruent with the Anabaptists' beliefs (L. Spears, personal communication, April 1, 2004). Spears also affirmed that Robert Greenleaf was

a man who was especially concerned with the growth and nurturing of people within their culture.

Thus far in the literature, an array of theoretical or conceptual models on cultural competence has evolved in the field of nursing research. Shen (2004) summarizes some of the major contributors to the advancement and development of culturally competent models in nursing, these include Leininger (2002); Campinha-Bacote (2003); Giger and Davidhizar (2004); Orque (1983); Purnell (2002); Spector (2004); and Andrews and Boyle (2002), among others. The Health Belief model (Rosenstock, 1974), Illness Behavior model (Mechanic, 1978), and Sunrise model (Leininger, 1991) were used to guide questions and observations during research of the Amish in the five seminal studies mentioned in Table 1. The Health Belief model was formulated to help explain (preventive) health behavior. The Illness Behavior model proposed a decision making process used by individuals to determine whether or not to seek treatment for symptoms. The Sunrise model was designed to explore comprehensive and multiple influences on care and culture. These models provided a conceptual framework that helped previous researchers assess specific questions on the knowledge and cultural influences that health beliefs had for the informants in the studies.

Schwartz (2002) used the Health Belief and Illness Behavior models to direct questions; however, she did not use them to prove or disprove any application of the models to the Amish culture (p. 140). The Health Belief model and the Illness Behavior model contain variables that apply to susceptibility, perceived seriousness or ramifications of receiving a diagnosis, and the internal monitoring of, and reparation to alleviate, symptoms. The Sunrise model by Leininger has been used to discover

worldview, life-ways, and cultural values of subcultural groups. It has been used in the literature to identify the most important social structure factors within a community or culture (Giger & Davidhizar, 2004; Leininger, 2002; Miller, 1997; Purnell & Paulanka, 1998; Wenger, 1988).

The Sunrise model constructs, now referred to as the Sunrise Enabler (Leininger & McFarland, 2006), correlated well with this study in terms of demonstrating the need to identify important social structure factors within a culture when wanting to assess culture. Two other models, Purnell's (1999) model for cultural competence and Giger and Davidhizar's (2004) transcultural assessment model, had relevance for this study based on the survey of literature. Purnell and Paulanka (1998, 2003) discuss the importance of using 12 different domains (heritage, communication, family roles, workforce issues, bicultural ecology, high-risk behaviors, nutrition, pregnancy, death rituals, spirituality, health care practices, and health care practitioners) to obtain specific cultural knowledge in order to maximize therapeutic interventions by becoming co-participants in diverse health-care settings.

The chapter on the Amish (chapter 4), written in part based on Wenger's (1988) dissertation study, uses the 12 domains from Purnell's model as an organizational framework to present the empirical evidence from Wenger's extensive research with the Amish people. Giger and Davidhizar (2004) illustrated how the six cultural phenomena (communication, space, social organization, time, environmental control, biological variations) housed in their model have been identified in various cultural groups, including the Amish. They asked contributing authors with expertise and clinical

background in the care of patients from the selected cultural groups to systematically apply the six phenomena to the assessment and care of individuals in that culture.

The legitimacy of using the Servant-Leadership characteristics for this study as a theoretical framework for exploration finds support in these models from the standpoint that Servant-Leadership fits well under the constructs of each of these three classic culture caring models. First, Servant-Leadership conceptually fits under the area of nursing practice for the Sunrise Enabler model. Using the specific characteristics and principles of Servant-Leadership, if found to be congruent, will help alleviate cultural care stresses and help provide culturally sensitive and congruent care. The essence of providing culturally congruent care is using supportive and facilitative acts or decisions tailored to fit an individual's cultural values, beliefs, and practices in order to provide meaningful, beneficial, and satisfying care that leads to health and well-being (Leininger, 1995).

Second, Servant-Leadership practice fits well under the cultural phenomena of social organization section for providing culturally sensitive care and environments in the Giger and Davidhizar (2004) Transcultural Assessment model. Culturally diverse health care requires cultural caring characteristics and principles be employed when assessing the social environment and identity of a client and making culturally sensitive interventions together (Giger & Davidhizar, 2004). The Servant-Leadership principles provide a lens through which to view the variables under this section of the model. These variables would include assessing family systems and roles, religious principles, values, symbols, rituals, education, and social support valued by Amish women.

Third, Servant-Leadership characteristics could be used practically under several sections (pregnancy, spirituality, health care practices, health care practitioners, overview/heritage) when assessing and delivering culturally congruent care in Purnell's model. The Amish perceptions of what defines caring by trusted care providers and how that caring affects their health and health-care decision making is part of the depiction of cultural domains and concepts (Purnell & Paulanka, 1998).

Utilizing many of the conceptual characteristics or attributes of Servant-Leadership as a lens through which to view cultural beliefs and practices and provide culturally congruent care was further substantiated in the literature. Several research studies, including the five seminal studies in Table 1, demonstrated the connection between using characteristics similar to those of the Servant-Leadership model to provide culturally congruent care and the characteristics valued by the informants themselves for the provision of meaningful culture care.

Leininger (2002) qualified that emic constructs from 54 culture studies listed caring characteristics and actions that were of value to informants of other cultures when providing culturally congruent care. Many of these constructs were synonymous with Servant-Leadership characteristics. The first four characteristics of Servant-Leadership—listening, empathy, healing, and awareness—were mentioned directly, while the other six were mentioned within characteristics that were synonymous in meaning. For example, being nonassertive while promoting health care practices aligned with the characteristic of persuasion in the sense that a non-assertive care provider will use a more culturally sensitive approach (such as persuasive techniques versus coercive ones) to encourage change. Accommodating and valuing another's cultural ways and incorporating their folk

practices were similar in context to the characteristic of conceptualization, which is in principle the same thing, conceptualizing ways to value another's lifeways.

The remaining four characteristics of Servant-Leadership also aligned with identifiable emic constructs from each of the cultural studies discussed above. Foresight aligned with the construct of being watchful and discerning; having knowledge of the culture you are working with and reflecting with them about the present and future preservation of culture. Serving and sharing with others aligned with a practice of stewardship, while being willing to be accountable and responsible both to and for others as well as caring about another's reality demonstrated a commitment to the growth of people. Restoration, community awareness, and culture care were illustrative of the attribute of building community.

Five transcultural nursing studies from diverse cultures were selected and reviewed on what culture care characteristics were valued by each culture and would be meaningful for the care provider to employ when desiring to partner with them in delivering culturally congruent care. For example, the characteristics of caring that were listed as important for North American Indian cultures and aligned with Servant-Leadership characteristics were actively listening, employing, and respecting healing from a folk perspective, and an awareness of cultural rituals and taboos (Leininger, 2002; Wittig, 2004).

Bohay (1989), in her study of pregnancy and childbearing in the Ukrainian culture, found that the informants specified certain characteristics that were viewed as being caring versus non-caring in professional nurses. If the nurses were viewed as being friendly and engaging by listening and interacting as opposed to showing no interest in

the informants, they were classified as being caring. Other characteristics of caring that were interpreted positively were for the nurse to be empathetic and caring to what the female informants were experiencing during childbearing and their preference for natural healing modalities. If the nurses expressed warmth and awareness by their encouragement and interactions, these characteristics of caring aligned with the beliefs of the Ukrainian culture of care as having presence, closeness, offering support and actively helping others toward healing (Bohay, 1989).

Rosenbaum (1990) encouraged care providers of the Greek to practice empathetic listening without prodding in order to build trusting relationships. Incorporating care characteristics that take into consideration the conceptualizing of the Greek folk health beliefs and health practices will assist the nurse in providing culturally congruent care to this cultural group. Other characteristics of caring that were identified for health care professionals to implement in their care plan when desiring to give culturally congruent care were showing awareness of what both stewardship and building community provide for the Greek culture (Rosenbaum, 1990; Leininger, 2002).

In her article on giving ethical transcultural care, Eliason (1993) purported that certain key characteristics are to be considered. These key characteristics were to listen carefully and only use language that is sensitive and inclusive. Clients were believed to be the expert on their own cultures, and nurses who demonstrate an awareness of what the client has revealed and expects will help conceptualize a relevant health care plan that can be mutually agreed upon. Eliason (1993) also said that to be committed to giving ethical and sensitive culture care one must be aware of one's own cultural beliefs in order to promote holistic healing in the decision-making process with the client.

The challenge for the health care provider or researcher based on the empirical data from these studies is to provide care from the informants (emic) values and care meanings, incorporating from professional (etic) knowledge with the informants' perspective in order to design and co-partner congruent care practices or interventions.

These studies presented culture-caring characteristics that connected in principle with the Servant-Leadership characteristics when desiring to give culturally congruent care, as did the five dissertation studies on the Amish outlined in Table 1. The ability to connect culture-caring characteristics valued by diverse cultural groups in their health care providers and the alignment with characteristics of Servant-Leadership in the literature provided a research basis and justification for this study. Many of the characteristics in Servant-Leadership are the same ones mentioned in regard to the characteristics revered by the Amish women themselves.

Two other studies that specifically explored Servant-Leadership in relationship to health care were: *Dimensions of Servant Leadership in American Not-for-Profit Hospitals* (Mason, 2002), and *Exploring the Values and Attributes of Servant Leaders* (Russell, 2000). These studies will be described in more depth due to the direct relevance they have to this study. Mason (2002) and Russell (2000) both noted general similarities in their studies concerning Servant-Leadership principles; first, the consistent theme that Servant-Leaders had the natural feeling of wanting to serve. Second, the difference made by employing Servant-Leadership principles was manifested in the care taken by the servant to verify that other people's highest priority needs were being met.

Mason (2002) advocated the use of Servant-Leadership practices among chief executive officers of four not-for-profit hospitals in America. The viability and success of



using a Servant-Leadership model was apparent in the observations and comments of both employees and CEOs of these hospitals. The 10 characteristics central to Servant-Leadership were evident in varying ways and degrees in each of the CEO's lives and work practices.

The primary objective of Mason's (2002) study was to gain deeper understanding of the nature of the phenomena of Servant-Leadership and to inform current and rising health care leaders and educators about the servant nature of their roles. His research questions all were well within the domain of Servant-Leadership: "How is Servant-Leadership practiced?" "What are the effects of Servant-Leadership in the culture of your organization?" and "What advice regarding Servant-Leadership would you give to health care administrators?"

The analysis of the study using a case study approach demonstrated that the CEOs who applied Servant-Leadership principles in their everyday practices were extremely successful and served their employees and communities well. Mason (2002) contended that utilizing the Servant-Leadership principles provided valuable insight and a viable model for administrators of health care. Mason (2002) stated the need for further research, particularly among women and minorities and in subjects in other career opportunities and settings.

Overall, Mason (2002) stated that utilizing Servant-Leadership principles did emphasize a desire on the part of the leader to increase service and caring to others. Servant-Leadership, according to Mason, was a useful model for health care administrators and providers who wanted to offer compassionate care. He found that applying these principles routinely encouraged personal growth and governance for the

administrator, while remaining sensitive to culture care and community building for those whom the administrator was serving.

Mason (2002) felt that the most notable aspect of the Servant-Leadership model practiced by the CEOs in the study was the admonition that we love our neighbors as we love ourselves. In an earlier study, Russell (2000) stated that Servant-Leaders acknowledge a holistic approach (recognizing interdependency, partnership, connection, and sharing of power) was necessary for culture caring to take place. Russell (2000) concluded that the use of Servant-Leadership characteristics was prominent in contemporary leadership literature. However, the validity of the model needed to be verified through additional empirical studies; he found this to be a void in the literature at the time of his study (Russell, 2000).

Russell (2000) discerned that there are five main functional attributes (vision, modeling, pioneering, appreciation of others, and empowerment) within the Servant-Leadership literature. These functional attributes also took into consideration Spears's 10 characteristics or attributes penned from Greenleaf's works. Russell believed that the 10 characteristics were a pre-requisite to the understanding of these five functional attributes; the approach increased the likelihood of promoting a sense of community and connection between all the main characteristics identified in the literature on Servant-Leadership.

Russell (2000) also traced Servant-Leadership through its theological foundations, beginning with Jesus Christ (the epitome of Servant-Leadership) and how Scripture supported the Servant-Leadership model. Russell (2000) advocated that Servant-Leadership is a preferable model with meaningful principles for those leaders who want

to serve others in their organizations. He also affirmed the functional characteristics of Servant-Leadership principles for leaders in his own working definition of Servant-Leadership. This definition of Servant-Leadership expanded the model definition of Servant-Leadership by founder Greenleaf (1977). Russell (2000) stated:

Servant-Leaders seek not to be served, but rather to serve. They view leadership positions as opportunities to help, support, and aid other people. Servant-Leaders create trusting work environments in which people are highly appreciated. They listen to and encourage followers. Servant-Leaders visibly model appropriate behavior and function as effective teachers. They have a high degree of credibility because of their honesty, integrity, and competence. These people have a clear leadership vision and implement pioneering approaches to work. Servant-Leaders are also conscientious stewards of resources. They have good communications with followers and exercise ethical persuasion as a means of influence. Servant-Leaders invite others to participate in carrying out their leadership vision. They empower people by enabling them to perform at their best and by delegating decision-making responsibilities. Overall, Servant-Leaders provide direction and guidance by assuming the role of attendant to humanity. (p. 66)

Russell's (2000) research questions focused on determining if any statistically significant difference existed between the attributes of Servant-Leaders and those of non-Servant-Leaders. To do this, 167 participants were divided into groups based on their leadership style (87 Servant-Leaders and 80 non-Servant-Leaders). Leadership style was determined by objective scores on the Hall Tonna Inventory of Values (Hall & Tonna, 1998) and the Leadership Practices Inventory tests (Kouzes & Posner, 1990). The statistical results provided strong evidence that of the attributes identified, four (vision, modeling, pioneering, and appreciation of others) were important elements of Servant-Leadership that did not appear in non-Servant-Leaders. Research included empowerment as a variable.

Russell (2000) surmised that the variable of empowerment is important in all types of leadership. Overall, the results established empirical support for most of the

characteristics of the Servant-Leadership model. The study established a need to further examine the link between values (core beliefs) and Servant-Leadership. Russell (2000) confirmed that the statistical results of his study provided strong evidence and empirical support for the attributes in the Servant-Leader model encompassing holistic service and partnership, compassionate caring, and connectivity.

### **Summary**

The literature suggests that care providers need to be more understanding of the complexities of an ethno-culture when seeking to give holistic care (Campanella et al., 1993; Hostetler, 1993; Kraybill, 1998; Leininger, 1991; Miller, 1997; Schwartz, 2002; Wenger, 1988; Yoder, 1984). Dissertation studies that specifically focused on Amish childbearing practices from the Amish women's perspective were limited, with only two studies (Miller, 1997; Nelson, 1999) exclusively describing childbearing practices from the perspective of Old Order Amish women.

There is considerable literature that lends validity to the concept that culturally congruent care decreases misunderstandings and builds mutual trust between the care provider and the client. Several studies (Miller, 1997; Nelson, 1999; Schwartz, 2002; Wenger, 1988; Yoder, 1984) have shown that Amish health care practices are strongly influenced by Amish women's religious and socio-cultural beliefs and practices. Culture care literature supports the theory that all nurses and researchers need to be more understanding of the complexities of a culture before entering the community to administer health care. This is especially significant when seeking to share information concerning risk reduction in a culture where separateness from society is practiced (Geiger & Davidhizar, 2004; Leininger, 2002; Purnell & Paulanka, 1998).

It was unknown if using a Servant-Leadership model to provide sensitive culture-care for Amish women might decrease misunderstandings and build trust during the childbearing time. There were no specific published studies examining the use of a Servant-Leadership model to gain insight for the teaching and promotion of health care during the Amish childbearing period. Research that enabled care providers to explore the use of a Servant-Leadership model to decrease misunderstandings between the care provider and the Amish women was identified as a void in the literature.

Discovering the potential for building trust relationships while helping the care provider better understand the situation from the client's perspective was well established in the literature (Miller, 1997; Nelson, 1999; Schwartz, 2002; Wenger, 1988; Yoder, 1984). The literature also supported using a Servant-Leadership model when the intent was to improve both the status of health and quality of life in the communities where care providers were invited to serve (Mason, 2002; Russell, 2000). Empirical support was established for most of the characteristics that writers have theorized are part of providing culturally congruent care to diverse culture groups and are similar to the attributes of Servant-Leadership (Bohay, 1989; Eliason, 1993; Leininger, 2001; Rosenbaum, 1990; Wittig, 2004).

The model of Servant-Leadership was shown to have a holistic approachability transferable across disciplines (Mason, 2002; Russell, 2000; Spears & Lawrence, 2002). Interviews with the Amish women themselves provided a rich firsthand data set from which to explore possible health care interventions that might have meaningful and culture-caring implications. Exploration through a Servant-Leadership model lens facilitated the possibility of exploring the health care reasoning and choices of Amish

women during childbearing from an emic perspective. Many of the principles in Servant-Leadership literature are the same as those mentioned in the literature with regard to the values revered by Amish women—listening, empathy, healing, stewardship, commitment to people, and building a strong community (Hostetler, 1993; Miller, 1997; Nelson, 1999; Schwartz, 2002; Wenger, 1988; Yoder, 1984).

The future of Servant-Leadership, according to Spears and Lawrence (2002), continues to be one that enhances our understanding and practice of people caring. One of Greenleaf's essays, "Education and Maturity," from *The Power of Servant-Leadership* (Spears, 1998), challenged Servant-Leadership practitioners to have a developing care responsibility toward people. People are to be trusted, believed in, and loved. This can only be done when we understand their life through their culture. Unless this view of people becomes dominant in our thinking we can never reach the height of our own significance and purpose, which is necessary for the fulfillment of life, nor can we be expected to ever connect in a significant way with their life and understanding (Spears, 1998).

Spears and Lawrence (2002) supported the logic that those who are willing to dig a little deeper into Greenleaf's startling paradox of Servant-Leadership will find interesting insights. Many minorities and less dominant cultures have long traditions and old roots of Servant-Leadership within their culture. Cultures that embrace holistic, cooperative, intuitive, and spiritual beliefs and practices center on being guardians of the future and respecting the forefathers who walked before them.

## CHAPTER 3

### METHODOLOGY

#### **Introduction**

The overall purpose of this study was to explore the childbearing health care beliefs and practices from the perspective of the Amish women and how nurse-midwives as Servant-Leaders may gain insight for the teaching and promotion of health care among Amish women. This study used the methods of ethnography to obtain knowledge and understanding about Amish childbearing women within the context of their culture. The information derived from the research laid the groundwork for understanding the childbearing health needs of Amish women and the implications for Servant-Leader care providers who seek to give culturally congruent care.

#### **Research Design**

Nurse researchers have discovered in more recent years that qualitative methods are valuable for gaining intimate knowledge of lifestyles and patterns from a holistic perspective (Leininger, 1995). This is important for an exploration of the cultural beliefs and practices of an isolated group. Leininger (1985) talked about how the paradigm in nursing needed to shift; in the past, nursing research was dominated by the prevailing quantitative methodology. Independent of historical, cultural, and social contexts, the

goal was to reflect logical positivism and an emphasis on viewing people as reducible and measurable objects.

Leininger (1985) established a new academic field of study called transcultural nursing to advance nursing knowledge in the study of human life-ways. In contrast, quantitative methods emphasize mechanistic modes that tend to reduce the study of humans and their care needs into numerical parts, which may not be the best approach for anthropological studies (Leininger, 1985). Qualitative types of research support the study of ethnographic gestalts, unlimited expressions, and totality of life-ways (social, religious, and cultural values within historical and meaningful life events). Ethnography allows for culture-sharing behavior of individuals to occur and supports a holistic approach in discovery of information from the participant's experiences and perspectives (Polit et al., 2001).

The selection of a qualitative ethnographic design was made to assist in the exploration and understanding of Amish women's perceptions about their childbearing-related health care beliefs and practices, as well as of the implications for care providers who seek to provide care in a culturally congruent manner. Qualitative methods were invaluable to this study for obtaining insights into new and different ideas largely unknown in the nursing field and for developing an approach for inquiry.

Nursing contains philosophical, epistemological, and historical beliefs that are deeply grounded in humanistic services to the human race. Qualitative methods are an essential means to discover and understand these rich domains of knowledge. The unique characteristic of nursing is care, the definition of which requires an array of qualitative methods for determining hidden and culturally based values of care (Leininger, 1985).



Leininger (1991) gave credence to the importance of using qualitative research when exploring a new area of knowledge and gaining fresh perspectives of nursing, stating that qualitative research methods would help reveal the nature and attributes of nursing beyond human response. Understanding the human in context with social structure, historical events, and cross-culturally varying environment aspects is best achieved through qualitative research methods.

### **Description of the Population and Sample Selection**

All of the participants were Swartzentruber Amish (nicknamed for a former leader), a distinct group within the Old Order Amish church. Swartzentruber Amish do not use any technology and resist all pressure to modernize their lifestyle or conform to worldly customs (Nolt, 1992). They are known to be an ultra-conservative people group who maintain that the use of automobiles, public utility electricity, and telephones undermines and breaks down family and community ties (Nolt, 1992). In this study, Amish women who resided in several small rural communities in the Midwest and were known to the “English” physician were invited by her to participate in the study. She was the research gatekeeper who set up the interviews with women clients who were willing to be interviewed. She had developed trusting relationships among many of the Amish families within the surrounding communities over the past 15 years, ministering to their health care needs.

The sample consisted of 7 Old Order Amish women (hereafter referred to as Amish women) between 22 and 62 years of age who had gone through childbearing or who were currently experiencing childbearing. Detailed information on each of the seven sample informants is within each of their Entry vignettes in chapter 4. All 7 women had

experienced childbearing, and averaged between 1 and 14 children each. It was not necessary to include criteria such as marriage status since Amish women who experience childbearing are married. Maintaining good Amish standing in the community requires active church affiliation and strict adherence to the *ordnung*, which accepts that childbearing out of wedlock is cause for shunning. A person who has been shunned is deliberately avoided by and excluded from the Amish community (Kraybill, 1998).

Purposeful sampling was used, affirming Patton's (1990) concept that the power behind purposeful sampling lies in selecting information-rich cases for in-depth study. Purposeful sampling made it possible to develop criteria for obtaining descriptions and rich data, thereby providing directional and sincere inquiry about what was needed in terms of knowledge about the Amish women from their perspective. A purposefully selected site helped in the exploration of the phenomenon to be studied since the gatekeeper was known and trusted by the Amish women in this study. The first seven women the gate physician asked randomly were the ones who ultimately became the informants for the study.

### **Domain of Inquiry (Stated Problem)**

The opportunity to explore the health care beliefs and practices of Amish women related to childbearing in a venue comfortable for them afforded an opportunity to examine the research inquiry in a naturalistic and unobtrusive setting. Provision of sensitive culture care to Amish childbearing women, who are believed to be at high risk for problems during the childbearing period, was identified as a problem in the literature (Buccalo, 1997; Campanella et al., 1993; Dellasega et al., 1999; Schwartz, 2002). No studies had been conducted examining how using a Servant-Leadership model to provide

sensitive culture care might be effective in understanding the health care reasoning and choices of Amish childbearing women. In order for the health care provider to provide culturally congruent care from the emic perspective, the care provider must become knowledgeable of the Amish culture (Miller, 1997; Nelson, 1999; Schwartz, 2002; Wenger, 1988; Yoder, 1984). These five seminal research studies identified the necessity to preserve and maintain as much of the Amish culture as possible when the goal is to build trusting health care partnerships. These studies are described in depth in chapter 2 and thus, further the understanding of the importance for health care providers to deliver culturally congruent care when risk reduction or interventions are desired.

### **Qualitative Instrumentation (Validity and Reliability)**

Many qualitative researchers have correctly offered alternative ways to think and express validity and reliability using qualitative referents. Leininger (1985) contends that determining validity and reliability for qualitative research is very different from what constitutes validity and reliability for quantitative research. The purpose, goal, and intent of these two types of research are obviously very different and require different criteria. Confirming the truths or understandings associated with an ethnographic event is the emphasis and essence of qualitative validity. Denzin and Lincoln (2000) and Morse (1994) also advocated the need to use relevant criteria to ensure trustworthy, credible, and accurate findings within the qualitative paradigm.

Patton (1990) encourages the use of high-quality evaluation techniques to ensure that collected data sheds light on the research questions, and that the analysis is relevant, rigorous, and understandable so as to be valid, reliable, and believable. Validity does not carry the same connotations as it does in quantitative research; it is the actual strength of

qualitative research (Creswell, 2003). Validity in qualitative studies is the preferred way to determine whether the findings are accurate and if there are credible and justifiable procedures for identifying and verifying that accuracy. Member checking is one of the most frequently used methods to determine validity of the findings. Taking the final report or specific descriptions or themes back to the participants to see if they feel they are accurate ensures the validity of the data (Creswell, 2003).

Validity is about using procedural perspectives to check for the accuracy of findings in qualitative research. The procedural perspectives used to validate the findings of this study are detailed below:

First, member checking was conducted to determine if participants felt that the data collected were accurate. Member checking was completed approximately 1 year after the initial data collection. Aware that my own self-perceptions and personal worldviews could affect the study, I felt it was crucial to use member checking to validate the trustworthiness and accuracy of the findings; it also helped to clarify and identify any personal bias that might have arisen during the study from nurse-midwifery experiences during my past work with Amish families.

Second, the use of rich, thick description to convey findings provided readers the ability to be transported to the setting and share the experiences. This procedure ensured validity through recreation of the experience using authentic voices.

Third, validation was accomplished by clarifying potential bias through open and honest narrative. All procedures used were discussed openly with committee members, including where the interviews were conducted, how the English physician invited the Amish women to participate in the study, how the interview questions were asked or

recorded, and how the field observations were obtained, so any potential bias could be assessed.

Fourth, I spent adequate time in the field to gain an in-depth understanding of the phenomenon. This time allowed for sufficient detail regarding the lived experiences of the participants, lending credibility and authenticity to the narrative.

Fifth, I employed the strategy of peer briefing; peer briefing occurred in order to ensure accuracy and allow the information to resonate with someone other than myself. Two professor cohorts, both of whom had excellent communication skills and had prior research experience gave peer briefing.

Sixth, an external auditor, who is an expert on Amish childbearing women's beliefs and practices, reviewed the entire project and provided an assessment at the conclusion of the study based on her many years of working as a healthcare provider and consultant for the Amish.

Seventh, the interviews were conducted outside the state where I practice as a nurse midwife so the participants were unknown to me at the time of the data collection. None of the participants had prior knowledge of the study, thus minimizing the potential threat to validity from personal bias toward the study or on behalf of a known care provider.

Eighth, the research questions were formulated with sensitivity to issues of cultural privacy. Care was taken to ensure that the questions were sensitive and culturally congruent with what the literature has implied.

Ninth, the dependability of answers given by informants was assured by validating and clarifying the findings with each informant during and after the process of

data collection. The informants were asked if the essence of what they said was captured during and after the data collection.

Tenth, handwritten notes were taken during the interviews; this was a more culturally congruent and accepted method than cassette or video recordings in a community that frowns on technology. The physician gatekeeper for this study also used note-taking when she visited an Amish home to provide childbearing care, thus it was recommended. Using a culturally congruent medium such as note taking increased the reliability and validity of the instrumentation because it did not create a threat to the Amish women's beliefs and practices. Reflection and journaling helped maintain the perspectives of the Amish women and ensured that technical rigor and any bias on the part of either party could be addressed.

Eleventh, utilizing the services of a university professor experienced in the usage of Taba allowed for a thorough check for consistency of theme pattern development and examination of stability and consistency of responses.

With respect to the criteria for assuring reliability in qualitative research, the focus is on identifying and documenting recurrent, accurate, and consistent patterns, and themes, in similar or different contexts (Leininger, 1985). Since a fallible person is observing, interviewing, and recording, the question "How reliable has the researcher been?" must be addressed. Markers for demonstrating the reliability of qualitative research described in the literature include the use of reliable and trustworthy methods by the researcher in his/her role as a research instrument. These markers include:

First, I needed to be familiar with the phenomenon and ethnographic event under study. This can be validated in this study through the fact that I am a professional

certified nurse-midwife who has worked with Amish childbearing women and families. I have also familiarized myself with current experts in the field and the scholarly and classic literature on the Amish, Culture Care Theory, and Servant-Leadership literature. I also am a member of the Transcultural Nursing Society and the American College of Nurse Midwifery and stay current with practice guidelines and theory development in both professional areas (See Vita).

Second, there needed to be a strong conceptual interest from a multidisciplinary approach. This study was approached from both a nursing and anthropological interest so as to holistically discover the perspective of Amish culture from the Amish women's viewpoint, or an emic frame of reference. As a nurse educator and researcher, I have long seen the value of documenting and interpreting as fully as possible the totality of culture from the people's own emic frame of reference.

Third, I demonstrated the skills needed to draw the participants into dialogue and sharing. These skills were further improved on during the course of the pilot study.

Fourth, I demonstrated how the core reliability claim centers on a potential social change. This was demonstrated in this study through the trust-building nature of the Servant-Leadership principles and is explained more fully in chapter 5.

Fifth, I demonstrated that the study had culturally congruent research questions. This lends good reliability measures for the study from the standpoint of being able to obtain within the time and resources social importance and scientific relevance in the study.

The research questions provided a framework for exploring potential cultural change within an ethno-religious group if the interventions are such that they are

culturally congruent and trusted, and the implications for transferability and future practice are demonstrated and are discussed in depth in chapter 5.

### **Pilot Study**

A small pilot study was conducted upon receipt of permission from the Andrews University Institutional Review Board to begin data collection. The pilot study provided opportunities for refinement and revision of the interview questions for the final research study and the ability to check the integrity of the research process. The pilot study afforded the freedom to tap into the Amish childbearing women's culture from their perspective. This pilot study process and the study results gave empirical significance in terms of reliability; this study verified that research was possible in the Amish world.

#### **Background of the Pilot Study**

The pilot study questions were constructed from field notes based on prior work experience, field notes, and observations with the Amish and also from literature and discussions with experts in the field of Servant-Leadership.

#### **Pilot Study Development and Prior Work Experience**

My prior work experience as a certified nurse-midwife with a fellow colleague and nurse-midwife who had lived and worked in an Amish community had a large impact on the development of research questions for the pilot study. My colleague lived in an Amish community for all her growing up years, returning to work as a nurse and then later as a nurse-midwife. She had over 100 childbearing women in her caseload of private patients at the time of our association as care providers to the Amish.



The purpose of my prior work with the Amish childbearing women was an exploration as part of career employment in health care rather than research. I was a full time clinical instructor for undergraduate nursing students at the time and was pursuing part-time work as a nurse-midwife. This experience resulted in a desire to study the lived experiences of Amish childbearing women from their perspective through ethnography and thus contribute to existing knowledge on deliverance of meaningful culturally congruent health care. The interactions between the Amish childbearing women and the nurse-midwife were observed in the Amish homes during pre-natal visits, post-partum follow-up visits and births, and follow-up at the Amish birth center. This experience contributed to the development of potential research and interview questions for the pilot study (see Appendix B).

### **Pilot Study Development and Servant-Leadership**

A careful consideration of Greenleaf's (1977) original writings was the inspiration for the classic penning of the 10 characteristics of Servant-Leadership by Larry Spears (Spears & Lawrence, 2002). Many of the characteristics in the Servant-Leadership model seemed to correlate well with the Amish beliefs and practices that were being observed during pre-natal visits and provision of childbearing care among the Amish women. These 10 characteristics seemed relevant for providing culturally congruent care in an Amish community that had experienced misunderstanding first hand in seeking health care.

This work experience with the childbearing Amish women gave me the opportunity to observe firsthand their health care beliefs and practices and helped to formulate the questions later used in the pilot study interviews. The pilot study itself was

conducted 2 years later in a different Amish community and health care practice. The 10 characteristics of the Servant-Leadership model (listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, and commitment to the growth of people and building the community) were used as the basis for organization of the field notes and the interview questions for the pilot study (see Appendix C).

### Pilot Study Overview

Amish women who were experiencing childbearing and who were using a community clinic with nurse-midwives to do the childbirth care were interviewed. A nurse-midwife who worked in a local women's clinic operated by the regional hospital set up interviews with 4 pregnant Old Order Amish women between the ages of 24 and 28 years with at least one previous child. Meetings were conducted on a prearranged day in the home of one of the Amish participants. Another nurse-midwife who worked for the clinic scheduled prenatal visits with each of the 4 women for the same day. This gave us an opportunity to talk as a focus group while the nurse-midwife conducted her prenatal visits in another room. The Amish women were very comfortable with this arrangement; it gave them the opportunity to be together in a supportive environment and have their appointment within walking distance of their home instead of at the women's clinic.

Three emerging themes became apparent in this early pilot study. First, Amish beliefs and practices were important to the Amish women and were practiced during childbearing. Second, a care provider to the Amish needs to provide care that is based on an understanding from their perceptions and what is important to them if the care is to be culturally congruent and meaningful and more likely to be followed. Third, there are

attributes of caring that a health care provider needs to have if their care is to be viewed by the Amish women as being culturally congruent.

The pilot study process and results gave empirical significance in terms of reliability for the actual research study via its validation of available literature pertaining to the three themes. The literature review in chapter 2 discusses more fully how these three themes are supported by the research literature. I felt the empirical support also was present for further exploration using the Servant-Leadership framework. Such exploration would discover if, in the telling their narratives from their own perception, the Amish childbearing women found the guiding principles of Servant-Leadership had significance for them from their cultural perspective.

### **Final Research Questions**

Three major research questions were addressed in this study and the way they aligned with the development of the interview questions are visually depicted in Table 3.

1. How did the ethno-cultural beliefs of Amish women influence their health care in childbearing?
2. Was there congruence between the Servant-Leadership model and Amish childbearing women's ethno-cultural beliefs?
3. What were the culturally congruent guiding principles of Servant-Leadership, which could assist nurse-midwives in their roles as educators and promoters of health care to Amish childbearing women?

The rationale behind the development of the research questions was simply to explore how from the Amish women's perspective their life experiences would answer the questions. The answers the Amish women gave in the interview questions had a

bearing on understanding how the research questions and the evolving themes were congruent in linking to the big picture of Servant-Leadership theory.

The first question focused on exploring the concept that if a woman believed her ethno-cultural beliefs influenced her health care, then how did those beliefs influence her health care and impact her decisions during childbearing? Interview questions 1-6 gave the Amish women opportunities to explore and expand on answering this research question. For example, as the women defined what health meant to them, a window of insight was opened to the importance of how good health vs. poor health meant being able to perform activities of daily living and meet the demands required of them. As a nurse-educator and researcher, I was aware that in most cultures being able to successfully perform activities of daily living is a criterion most people use when defining their health.

The second set of questions (7-20) related directly to the second research question. Exploring from the perspective of the Amish woman and what she valued in a care provider and how they could best serve her would hopefully reveal attributes that she desired her care provider to have. At that point a comparison would be possible in terms of those attributes voiced by the Amish woman and the attributes of Servant-Leadership in terms of congruency.

Table 3

*Correlation of Interview Questions With Research Questions and Their Relationship With the 10 Characteristics of Servant-Leadership*

Interview Questions	Research Questions	10 Characteristics of Servant-Leadership
1-6	How do the ethno-cultural beliefs of Amish women influence their health care in childbearing?	
7-20	Is there congruence between the Servant-Leadership model and Amish childbearing women's ethno-cultural beliefs?	Variations of all 10 components of the characteristics of Servant-Leadership are assessed.
21-34	What are the culturally congruent guiding principles of Servant-Leadership that assist the nurse-midwives in their role as educators and promoters of health care to Amish childbearing women?	All 10 characteristics are affirmed a second time: Questions 21, 22 (listening) Question 23 (empathy) Question 24 (healing) Question 25 (awareness) Question 26, 27 (persuasion) Question 28 (conceptualization) Question 29 (foresight) All Question 30 (stewardship) Question 31, 32 (commitment to the growth of people) Questions 33, 34 (building community)

The third set of interview questions (21-34) were specifically designed to explore the attributes or principles that make up Servant-Leadership, and if they held any value or importance for the Amish women.

### **Data Collection and Analysis**

Data were collected using semi-structured interviews and field observation techniques. The Servant-Leadership model was used to guide the development of culturally sensitive questions based on the literature review. For example, one of the characteristics of Servant-Leadership is to show awareness for the desires of those you seek to serve. Being aware that Amish women do not accept the use of taped recordings of direct conversations of their voices eliminated the possibility for using that form of technology when interviewing the participants. The Amish view the tape recorder as being similar to taking or creating an image of themselves, an action that goes against their religious beliefs (Hostetler, 1993). As an alternative, I carried a notebook with me and took handwritten notes during our conversations, transferring them to a computer after completing the visit.

Entrance into the Amish community was attained through a physician, recommended by a mutual friend who works with her in various cultural groups overseas. Upon contacting her and explaining that, as a certified nurse-midwife who works among Amish childbearing women I would like to improve my ability to serve Amish women in a more culturally congruent manner and in alignment with their beliefs. By participating in this research study they could open windows of opportunity perhaps for that to occur.

She agreed to talk with her clients and determine if there would be an interest. The physician was able to assist in obtaining opportunities for and scheduling the interviews.

I was invited to come and stay in the community so I could be near where the Amish families lived (my home is approximately 8-10 hours away in a neighboring state). Living in the community also gave me the opportunity to make rounds with the physician so that additional observation time could occur. The participants understood that the questions to be asked were based on the hope that the information gained would aid care providers in their understanding of Amish childbearing beliefs and practices, thereby providing care providers the opportunity to improve the care they provide to Amish women during childbearing. Each participant was given a study entry form explaining the background and reasons for the study (see Appendix A). Each interview was approximately 1½ to 2 hours in duration, a similar amount of time to that which a nurse-midwife spends during a first prenatal visit with an Amish patient. Also, over the course of 3 weeks additional observation and participation time was spent on community rounds with the physician to Amish homes.

My time spent in the field was adequate in that the data already were beginning to be saturated with similar results. I was comfortable interviewing and spending observation time with the Amish women in the venue provided. I had spent considerable time in other Amish communities over the course of 2 years—as a clinical instructor, a nurse educator for a university nursing department, and later as a researcher in a pilot study. My comfort zone in interacting with the research participants was enhanced by my understanding and familiarity with the Amish culture. The research process was tracked by journaling field notes and hand-recording the interviews in my notebook, recapping

with the participants and reviewing the notes after completion of each interview. I did not transfer my thoughts via tape recording at any time, even in the car, as the presence of a driver would have compromised the confidentiality of the participants.

Research time was composed of observation, observation and interviewing participation, active participation, and observation and reflection. Approximately 15% of the time was spent in observation, with the focus on observing the whole context of the Amish culture in the Amish community through my family visits. This type of observation involved friendly exchanges and identification of the social structure and recording data as seen, heard, and experienced. Approximately 55% of the time was spent in combined observation and participation, focusing on the domain of inquiry while participating and interacting directly with the 7 participants. This was the most intense time in terms of collecting the data through semi-structured interviews. Active participation accounted for an additional 20% of the time, with my inclusion in many health and care rituals and activities, including helping with prenatal and post-partum visits. This afforded time to observe interactions as I participated in a more direct manner in the health care of the Amish women. Finally, 10% of my time was spent in observation and reflection, validating my conclusions of meanings and themes with the participants.

During the observation phase I used a notebook with lined paper as a fieldwork journal to record my observations, reactions, and early analysis, with categories pertaining to the research questions for organization. I correlated any relevant Amish terms or explanations with the three research questions using verbatim comments that expressed a theme or pattern. The journal also contained a record of experiences—any ideas, concerns, breakthroughs, or challenges that occurred during my visits. This seemed



appropriate in terms of categorization, because most of the visits were health-care related. I also recorded any ethno-health or ethno-caring terms that were mentioned. For example, the informants may speak of the “English,” meaning non-Amish, or “us plain people,” meaning the Amish during a discussion. Another example would be clarifying an event by saying, “this is our Amish ways,” meaning the way of the *ordnung* vs. English or non-Amish ways.

During the observation-participation phase, I was struck again with the significance of how important and valuable an in-depth interview can be as opposed to handing out questionnaires and not taking the opportunity to speak face to face. The expressions, the spontaneous ideas, and the contextual inferences made by the Amish women all added richness and depth to the meaning of their stories. The participation phase provided a hands-on opportunity to connect personally with the Amish women, yet in a way different from the note taking and interviewing. The Amish childbearing women related to me more as a care provider, and sought my opinions as a nurse-midwife.

All of the phases were insightful and added detailed data to the study. The final phase was where reflective validation occurred; after 1 year I took my observations and themes back to each of the key informants in their homes and asked for their opinions on the accuracy and reliability of the findings. This experience was affirming and meaningful for all concerned. It also gave me the opportunity to again say “thank you” to these women for allowing me to enter their world and learn from their lives. The Amish women were quick to affirm what was correct and what was not. We had built a relationship of trust, and the ability to speak openly. This was evident in their joy and welcome when seeing me again.

Analysis of the data was an ongoing process throughout the field research. As I observed, interviewed, and recorded findings, themes and patterns began to emerge. Whenever possible, I separated the data into categories pertaining to the three research questions using Taba, an inductive information-processing tool that allowed me to build classifications of the responses based on the like characteristics of their meanings. This effort helped me to organize data all along the process and was very valuable when it came time for analysis. Data were transcribed onto my computer from the interview and field notes as well as journal entries from the observation, active participation, and validation phases. I then used Microsoft Word software to construct a page setup and layout using line numbers. Line number allowed me to have a continuous, running transcription of the dialogues and findings. I then printed all the sheets and analyzed carefully the observations and responses to find common constructs using the Taba method of classification.

Each construct was color-coded, with a different color assigned to each of the three research questions. Then cards with all the constructs listed were created, and I began to classify the constructs to determine how best the data could be classified into categories and main themes. Once my themes were confirmed, I had a university professor experienced in the usage of the information processing tool “Taba” check for the stability and consistency of the analysis process. He was able to provide valuable in-service and assistance on the usability of Taba as an information processing tool throughout the study and verified the reliability of my findings. I personally liked using Taba as opposed to a software package like N-Vivo because it allowed me to be closely

connected with the data at all times. Having the cards and sheets readily available made transport easy in whatever venue I was working.

The themes identified through this process aligned well with the research purpose and findings. Having semi-structured interview questions made the task of identifying the frequency and similarity of responses under each specific research question somewhat less cumbersome. I then could synthesize the themes into patterns of empirical and higher order statements that had significance in terms of research findings.

### **Summary**

In summary, ethnographic qualitative methodology was used to increase and expand the understanding required to add to the body of knowledge about Amish women's beliefs and practices regarding childbearing. This approach allowed exploration of the Amish woman's cultural views and practices concerning health care as a resource for care providers to gain insight for the teaching and promotion of health care. My use of semi-structured interview questions, developed specifically to explore the constructs of the three research questions, led to an understanding of the informants' cognitive processes regarding the manner in which they live and believe (lifeways). I was able to categorize their perceptions about the importance that cultural practices, concepts of caring and congruent principles have on their childbearing health care. In chapter 4, explorations and analysis of the data in relation to the research questions are described.

## CHAPTER 4

### RESULTS

#### **Overall Purpose of the Study**

The purpose of this study was to explore the health care beliefs and practices of Amish women related to childbearing, and how nurse-midwives as Servant-Leaders may gain insight for the teaching and promotion of health care among Amish women. The goal of the study was to use ethnography to gain knowledge and insight about Amish childbearing women within the context of their religious and socio-cultural environment. Knowledge derived from the research data helped lay the groundwork for understanding the childbearing health needs of Amish women and the implications for care providers who wish to give culturally congruent care to Amish childbearing women.

The Amish in the United States have a unique culture that influences the health beliefs and practices of its childbearing women. Certain Amish lifestyle traditions promote healthy pregnancy outcomes, such as having an extensive psychosocial support system in the family and community. Other lifestyle choices influencing pregnancy outcome include abstinence from smoking, alcohol, and drugs, and the value placed on motherhood and children by other members of their society (Campanella et al., 1993). However, Campanella et al. (1993) also identified perinatal risk factors prevalent among Amish childbearing women that increase their risk during pregnancy. These factors included short birth intervals, giving birth to many children, increased births to older

women, consanguinity (marriage to blood relatives), increased rate of twinning, a diet often high in fats and sugar, obesity, lack of medical insurance, late entry to prenatal care, and attending fewer prenatal visits by choice. Consequently, traditional non Amish health care providers often find it a challenge to provide culturally congruent childbearing care that also meets the health needs of this ethno-religious population.

An understanding from the Amish childbearing woman's perspective facilitated an insight into how using a theoretical model, such as the Servant-Leadership model, could contribute to a decrease in misunderstandings, and thereby better enable the nurse-midwife/care provider to implement culturally sensitive and positive pregnancy-outcome care. Before attempting to implement interventions such as education about childbearing, health promotion, or prevention, the care must be culturally acceptable to the Amish. If not considered acceptable, the practice will not be followed or even considered (Schwartz, 2002). Utilizing a culturally congruent model would have value for a people group who desire more information and who esteem care providers who are sensitive to their cultural beliefs and practices.

Three research questions were addressed in the study. These were explored through case studies. The key information contained in the case studies demonstrated the confluence of the themes with the three research questions. Patterns and themes began to surface as early as the first interview. Since the data was already categorized within the research questions three distinct themes began to emerge consistently. It was visibly apparent once the constructs were colored coded how they systematically fit in terms of categories and later themes. The themes identified through the Taba process aligned well with the research purpose of exploring the health care beliefs and practices of Amish

women related to childbearing, and how health care providers may gain insight as Servant-Leaders for teaching and promotion of health care within this culture. The themes are discussed below as they related to the research questions.

1. How do the ethno-cultural beliefs of Amish women influence their health care during childbearing? This relates to Theme 1: Cultural beliefs are important and practiced during childbearing by the Amish women.

2. Was there congruence between the Servant-Leadership model and Amish childbearing women's ethno-cultural beliefs? This relates to Theme 2: Concepts of caring are part of the culture of caring described by the Amish women and need to be included in the practice of the care provider if the plan of care is to be meaningful and followed.

3. What were the culturally congruent guiding principles of Servant-Leadership, which could assist nurse-midwives in their roles as educators and promoters of health care to Amish childbearing women? This relates to Theme 3: Congruent principles need to be used by the nurse-midwife or care provider for culturally sensitive care to the Amish childbearing women to occur.

Each of the research questions and their related themes were assessed using a case study framework. Researchers have advocated using this methodology in their description of the case study approach (Denzin & Lincoln, 2000; Stake, 1995).

Utilizing the concepts of Entry vignettes, Issue development, and Assertion strategies lent a stable venue for description within a case study construction and organization. Each Entry vignette section contains background information concerning the participant. The narrative detail was explored within the Issue development section, which examined the participant's responses to the research questions. This key

information helped to describe the case and answer the research questions as well as demonstrated the confluence of the themes with the three research questions. The Assertion section provided information that allows the readers to consider the knowledge of the case. It also summarized how I as the researcher understood the case, and generalizations about how the case supports the information pertaining to the issues of development and the confluence with the themes. In the world of the Amish these issues are their life narratives, providing support for the information they gave that led to the development of the research themes. I included in the Assertion section what had been done to confirm the data by talking with other sources that may have other opinions in order to triangulate the data.

### **Case Study 1**

#### **Entry Vignette: Background**

At the time of our initial interview, Mrs. A was a 42-year-old Amish woman who graciously agreed to come and visit in the gatekeeper's home. A 1-year follow-up interview session for validation later was conducted at Mrs. A's home. Mrs. A had often come to the home of the gatekeeper seeking consultation, medical treatment, or for a friendly visit. She appeared very comfortable and chose a chair to my left, allowing for good eye contact. She agreed to share with me her beliefs and practices as they pertained to and influenced her choices for health care during her childbearing period. She acknowledged that she understood the intent of the study and affirmed she was happy to help.

Mrs. A was relaxed and had a very pleasant expression, appearing to consider her words carefully before speaking. She described her children with beauty and detail. It

reminded me of an artist depicting, on canvas, a lovely scene. The sparkle in her eyes spoke of her love and deep affection for her children. Several stories came out as we were filling out the demographic page. She preferred that I fill in the blanks while she talked; a less intrusive mode of information gathering.

Mrs. A had attended Amish schools through the eighth grade, and married at age 19. Her first baby was born at age 20. She had worked outside her home for other Amish families as a mother's helper prior to her marriage. She does read several of the Amish newspaper and magazines such as *The Budget*, *Plain Interest*, *The Diary*, and the German Bible, but does not generally read non-Amish literature (she may occasionally look at Christian literature given to her by friends). She does not have a TV or listen to the radio, pastimes in keeping with what she interprets as worldly practices. She shared her experiences from her 16 pregnancies with a radiant smile and sparkle in her eyes, giving a short description of the birth of each baby by name. A distinct sadness entered her eyes when she mentioned the two miscarriages she had between the births of her third and fourth children.

During her description of her third child, a daughter, Mrs. A sadly disclosed the fact that this daughter, now age 20, has left the Amish ways, and is raising her little boy with her husband who also left the Amish community. She said she had very high hopes that the daughter would come home soon and bring the baby, her grandchild, to stay. I noted that she must really miss her daughter and the baby, sharing that I really miss our daughter and grandchild who live far away. Mrs. A responded that the daughter does come and bring the baby to visit with her, which helps, but is not the same as having her



close. Since the daughter has not been baptized, she is not under any shunning practices at this time and therefore is free to visit the family as she chooses.

### Issue Development

#### **Research Question 1/Theme 1**

Mrs. A. provided several examples of how her beliefs as an Amish woman had influenced her health care choices during childbearing. She explained how her days are full with hard work as she cares for her family; having a strong work ethic is an important tenet in her beliefs regarding caring for her family and helping others. This is a God-given role and very much a part of the Amish way. Mrs. A said that having the skills and ability to do the work required to raise 14 children and operate a household without modern conveniences is especially important during childbearing and defines “good health.”

Each baby is a gift from God, and large families are a blessing. Mrs. A emphasized the importance of leaning on her Amish community for support, obtaining advice from experienced Amish friends, and staying connected. She felt, from her experience, that non-Amish or English care providers would be able to provide much better care if they were knowledgeable about Amish ways. Mrs. A felt that an English care provider must particularly understand the significant differences between Amish ways and those of the English. Without this understanding, the care provider would not be able to be a partner in Amish childbearing care. The Amish appreciate practical knowledge and advice that shows consideration of their work and their ways, including their desire to use a more natural approach to childbearing—one that is safe and yet low cost. Knowledge of herbs and natural remedies is appreciated, particularly in light of the

belief that God's ways are natural, according to Mrs. A. She felt that He has given us many natural things for healing, and these should be used as a first preference.

It is very important for care providers to be sensitive to their clients' needs, Mrs. A said, this requires listening with your heart, your mind, and your senses. Staying tuned in to the woman and being open to suggestions without rushing the experience are very important.

### **Research Question 2/Theme 2**

Mrs. A was asked questions that directly pertained to her relationship with care providers during childbearing. She reiterated the importance of listening, of being understood from her Amish perspective, and of the care provider's ability to value the healing ways important to the Amish woman. She also wanted the care provider to be aware both of her feelings and their own feelings concerning Amish ways. Mrs. A reiterated that she did not want to be coerced, but gently persuaded if something was important in terms of interventions. She said she wanted her care provider to conceptualize their practice to incorporate many of the Amish health care beliefs and practices.

Mrs. A stressed the importance of an open, trustworthy, and sharing nature on the part of the care provider; a willingness to share stories from the past that worked well during childbearing. She valued the concept of care providers who see their calling as a ministry and stewardship. According to Mrs. A, seeing your job as a ministry meant committing to others in service. She holds that stewardship is a high calling, which would naturally mean demonstrating a caring, unselfish spirit towards others. She felt this is one of the ways that we can give back to God.

**Research Question 3/Theme 3**

Mrs. A seemed very comfortable in describing how each one of the 10 characteristics of Servant-Leadership assessed in the last 14 interview questions were important to her. She reiterated how good she felt when she knew her care provider was listening to her. It was an important part of being affirmed and that she was offering something worthwhile to the conversation. It also gave her the assurance that her questions and responses were intelligent and valued. She distinctly remembered a time when one of her English midwives at the birthing center was thoughtful enough to ask her if she desired TV or background music. Mrs. A felt this was very considerate of the midwife, and a good example of being sensitive and demonstrating empathy for another's beliefs and practices. Such sensitivity must be a hallmark of practice if trust is to be developed, she thought.

Mrs. A mentioned several times that natural healing practices are a valuable part of the Amish ways. If a care provider was knowledgeable in using more natural ways to treat symptoms that may arise during childbearing, then the suggestions would be highly regarded. Mrs. A expressed that for her a care provider to show awareness of the Amish ways and be willing to incorporate interventions that were sensitive to her beliefs would help to build consensus and trust in that care provider, and she would most likely follow the suggestions. Since her days were very full of hard work even during childbearing, an understanding approach instead of attempting to force or to coerce her also would build a partnership of trust. Since coercion is very alien to the Amish ways, seeking to serve her as she serves others in open, generous, humble, and unselfish ways would be appreciated and most accepted. Caring for others and being committed to the best interest of others

and the interests of their community is part of the Amish way, and is congruent with her valued beliefs and practices.

#### Assertion

Mrs. A affirmed that the ethno-beliefs of Amish women influence their health care during childbearing and are important for non-Amish or English care providers to understand. Also, Amish women value certain characteristics in their care providers—those characteristics that are synonymous with Amish ways. These include listening to their client's story and empathizing with the client from their own life journey, valuing holistic healing from a simple and Amish cultural perspective, being aware of others' feelings and orientations to life, and persuading gently when the need for interventions occurs. Care providers who give guidance and share lessons from the past, holding in trust the desire to serve others unselfishly, were important to Mrs. A and would, in her opinion, help build community and trust among the Amish women and families.

The correlation between the Servant-Leadership model characteristics and the beliefs and practices that Mrs. A held to be important during childbearing were readily apparent. The incorporation of a similar model that aligned well with these beliefs would build trust through congruent understanding.

#### Triangulation Source for Assertion

A young mother who had left the Amish community came to visit with the physician where I was staying. She was happy to talk with me privately, and I felt this would be a good chance to have another source of opinions to triangulate the data. She reiterated the importance and place that the *ordnung* teachings have in the beliefs of the

Amish. Mrs. A had known that this young girl and possibly her own daughter might pay me a visit at the physician's house. This young woman was a close friend of Mrs. A's daughter and had also left the Amish community. She reinforced many of the things that Mrs. A had said that were important to the Amish culture. The young woman expressed that beliefs are very strong and permeate every aspect of their lives.

The young woman felt that if a care provider understood the principles of the *ordnung* they would be in a much better position to help the Amish women. She admitted that there are still things she herself does not understand in terms of the rules, and if she did, it might have made a difference in her leaving the Amish community. She felt it would be very hard to come back because she would not be seen in the same light and things could never be the same. The young mother shared that she misses her close-knit Amish community and her family. She also misses the Amish dress. This surprised me somewhat, since she seemed comfortable in the English-style jeans and T-shirt. When I asked her about this, she mentioned that her husband liked her to dress this way and going back to wearing the Amish clothes would not be right because they stood for a lifestyle that she was not living.

We discussed why, when so many of the Amish ways were embedded within, she did not openly ask for explanations from her family or church leaders if she had questions concerning aspects of the culture she felt were inconsistent. She shared with me that she was not taught to critically think through the "whys" and "why not's"; her place was to accept and obey, not question the teachings of the *ordnung*. The practice of accepting and obeying without question is part of being submissive and humble; children are not conditioned to ask why, but to emulate the behavior of Amish adults (Huntt, 2001). She

felt that if she had understood more at the time about the values and their rationale behind them she most likely would not have left her Amish community. I could not help feeling sad, knowing how Mrs. A and this young woman's parents both so desperately wanted to have their daughters back. The young woman shared that she has given thought recently to taking her baby and going back to live with her Amish family, but was very torn because she did not feel the baby's father would come with her.

## **Case Study 2**

### **Entry Vignette: Background**

Mrs. B is a 37-year-old Amish woman who has been a childbearing client of the physician gatekeeper for the study, and still sees her for well-woman visits. Mrs. B agreed to meet with me on two occasions in her home to discuss her childbearing experiences and share her thoughts on my questions concerning Amish childbearing beliefs and practices. She understood that I would be conducting a study over the course of the next year to gain information on how nurse-midwives and other care providers who work with Amish families can make childbearing a healthy and meaningful experience for Amish women.

Mrs. B and I chatted easily as we filled out the consent form, and I described the study in more depth. Mrs. B attended Amish schools in Ohio up through eighth grade and has lived in the area with her husband for 17 years. Mrs. B has a contagious gift of good humor and hospitality, and welcomed me into her home on both occasions. She expressed a desire to help with my study in any way she could. Mrs. B was very easy to talk with and seemed to enjoy sharing any of her experiences that could be meaningful to my research.

Mrs. B worked as a mother's helper in Amish homes before getting married at age 20 and having her first child by age 21. She used herbs extensively during childbearing, including red raspberry, flaxseed, late pregnancy drops consisting of white oak bark, blue cohosh, red raspberry and squaw vine, vitamin supplements, and teas for sleep. She enjoys reading Amish magazines such as *Plain Communities* and *The Diary*. She also reads some English journals such as the *Filmore County Journal*, *English Weekly*, and a variety of herbal magazines.

Mrs. B explained her philosophy that children are a special gift from God and shared many details about her pregnancies and their outcomes. All except one of her children was born at home. Out of 12 pregnancies, she has 6 living children. The love and affection she has for her children was obvious in both the expression on her face as she talked and in the way she described them and their ways.

Mrs. B described the six babies who had either been miscarried or died as infants with deliberate accuracy. Her openness to share and accept the death of her children as part of life and the healthy way she deals with their memories were very moving, and beautiful, and captivating. Mrs. B brought out a memory trunk filled with little dresses and memorabilia of her daughter who had died from complications of dwarfism at 8 months of age. She expressed with compassionate affirmation and understanding her belief that her miscarriages and stillborn child were part of God's plan for her life. There was no trace of bitterness, just a matter-of-fact acceptance of and thankfulness that her children were no longer suffering, as well as pleasure in her living children whom she felt were a joy and blessing to their home.

Mrs. B's oldest daughter has completed her eighth-grade compulsory education as a scholar and is now helping with the home responsibilities at age 16. During both of my visits to their home, Mrs. B's eldest daughter was friendly and, like her mother, has a gift for hospitality and connecting with people. The daughter offered me tea and homemade cookies, and always took the time to greet us warmly. When her mother spoke of the lost children, the eldest daughter would nod her head in agreement and seemed to enjoy looking through the memory trunk with all the babies' things.

Mrs. B also shared that, to her, health meant feeling good so she could do her work. This was important to her, as a valued part of the Amish lifestyle is cultivating the ability to do your work well and take good care of your family. Her basic philosophy that each baby is a gift from God even if the pregnancy or baby is not healthy has helped her obtain closure after their deaths. She said many of her family members and other Amish women in her church advised her to have massages, often known as chiropractic manipulation, as health-maintenance therapy.

Mrs. B felt that health care providers who want to be providers for Amish women need to understand and be sensitive to their client's needs, ways, and perspective. She said she always appreciated having a care provider who was friendly and caring and took extra time to get to know about her as a person. Having a good sense of humor and being positive in their orientation to life were characteristics valued by Mrs. B. She also prefers a more natural approach to childbearing, one that actively uses natural herbs and remedies—her concept of the Amish way.



## Issue Development

### **Research Question 1/Theme 1**

Mrs. B. explained that being able to do her work was an important tenet in her belief about taking care of her family and helping others. She also felt that doing ones work cheerfully and unselfishly is a God-given role, and very much a part of the Amish ways. Mrs. B affirmed the importance of having her family and the Amish community for support and advice. She felt that care providers would be better equipped to be a partner in her childbearing if they both understood and accepted her health care beliefs and practices. Using simple and practical methods that fit into her work and lifestyle would build trust and assure her that the care provider truly cared about being sensitive to her worldview.

### **Research Question 2/Theme 2**

Mrs. B thinks it is very important for care providers to be fun to be around and to listen and be open to suggestions without having preconceptions. She affirmed as well that her trust grows if she is encouraged to take an active part in the care of herself and her baby. A caring and non-critical attitude on the part of the care provider would demonstrate the value that a culture of caring has for the care provider and would attract her to that care provider. Attempting to coerce her into something against her beliefs would only alienate her. She believes that God gives the gift of healing to people, and shared that she felt her husband has the gift of using massage for healing. A care provider who used their gifts in humble and unselfish ways would be more readily accepted; such an approach would be similar to how the Amish use their gifts to help others. Mrs. B said this would mean, for example, that if a non-Amish person sees their gift, such as

midwifery, as a ministry, that belief would be very compatible with how she herself views the way gifts of healing should be used and practiced.

### **Research Question 3/Theme 3**

Mrs. B was asked questions directly pertaining to the 10 Servant-Leadership principles. She reiterated the importance of listening, of being understood from her Amish perspective, of the care provider's ability to value the healing ways that were important to her. She also wanted the care provider to be aware that even if their practices or interventions were contradictory to hers, she would be more open to accepting them if the care provider conceptualized their practice to incorporate as many of the Amish health care beliefs and practices as possible. Mrs. B also stressed the importance of a care provider who is open, trustworthy, and willing to share stories of what worked well during childbearing both in their own life as well as in their practice. She valued the concept of a care provider who sees their calling as a ministry and stewardship.

Mrs. B shared that care providers, such as a midwife, who would be willing to practice in the Amish homes, would be a good way to build community and show commitment to the Amish community.

### **Assertion**

Mrs. B affirmed that the ethno-beliefs of Amish women influence their choices and health care during childbearing. She felt that Amish women would be more likely to use interventions that correlated with their Amish ways. Mrs. B felt Amish women value certain characteristics in their care providers, including listening, showing empathy, employing natural healing treatments as a first option, etc. Exhibiting an awareness and

acceptance of others' way of living, persuading gently when the need arises, offering culturally sensitive guidance, sharing what has worked in similar situations from the care provider's experience, and holding in trust the desire to serve and commit to others unselfishly also are highly valued.

The congruence between the Servant-Leadership model characteristics and the beliefs and practices important to Mrs. B were strikingly apparent.

#### Triangulation Source for Assertion

I had the opportunity to speak several different times with an English couple who drive for the Old Order Amish in their community. Many of their shared observations were similar to my own; they have become friends and built trusting relationships with the Amish community. They confirmed that using a Servant-Leadership model that contained these 10 characteristics would have value for them as they continued to befriend and help the Amish in their community. They noted that the Old Order Amish in their community were very suspicious of outsiders and were surprised and excited that the Amish women in this study were willing to open up and share with me as they had. It has taken them several years to gain trust with the Amish community. I explained that it was only by having the physician as a trusted gatekeeper that the door was opened so I could have the intimate discourse that occurred during the year the study took to complete.

### Case Study 3

#### Entry Vignette: Background

Mrs. C is a 22-year-old Amish woman whom the gatekeeper of the study assisted with her pre-natal care of her first infant a year before my initial visit. Mrs. C agreed to talk with me about her childbearing experiences and share her thoughts on the questions concerning Amish childbearing beliefs and practices. She liked the idea that a study was being conducted to gain information on how nurse-midwives such as myself and other care providers who work with Amish families can make a healthy and meaningful childbearing experience for Amish women. She especially liked the idea that the information would be based on Amish women's perspective of what is important for their care providers to know and understand.

She lovingly and proudly brought her beautiful little one year old baby over to see us from his homemade cradle; he was apparently thriving and doing well. The sparkle in her eyes gave away her love and deep devotion for him. She had her mother, who was an Amish lay midwife, assisted in the delivery of her son. She felt everything went very well, and really liked having her mother there to support her as a care provider. It made her feel very safe and cared for. Mrs. C attended Amish schools up through eighth grade, and she and her husband own a furniture-making business. Mrs. C was married at age 20 and had her first baby at age 21. She had worked as a mother's helper prior to getting married but never worked outside of her Amish community. She enjoyed reading mostly Amish literature such as *Plain Communities* and her German Bible. She used herbs extensively during pregnancy, including red raspberry, late pregnancy drops, and alfalfa for milk production, along with vitamin supplements and teas for rest.

## Issue Development

### **Research Question 1/Theme 1**

Mrs. C readily shared her perspective using the questions for discussion points. I noticed by the second visit that she was even more visibly relaxed and treated me like a trusted friend. She shared that health to her meant feeling good so she could do her work during pregnancy, which was very important. Healthy childbearing meant feeling good, not having pain, and feeling strong. She initially felt as though she was not as experienced as older Amish women in answering some of the questions, but became much more comfortable as the interview continued.

Mrs. C said she relied heavily on her mother and other Amish women in her family to give her advice on childbearing and what she needed to do with this first pregnancy. Some of the advice included recommendations to use lots of fruits and vegetables, rest when she could, take prenatal vitamins, use red raspberry tea, and late pregnancy drops. She also thought it was important to let her husband carry heavy things, such as water for laundry, while she was pregnant. She felt the advice she was given was important because it came from trusted family members and other Amish women. She also felt that the information passed down from Amish forefathers and mothers was valuable and worthy to be followed.

### **Research Question 2/Theme 2**

Mrs. C thought that it was very important for the health care provider to be sensitive to their client's needs. For instance, the health care provider needs to really listen to what the pregnant woman is saying and be informed about what is happening to her. She always appreciated having a care provider who asked her "good" questions,

especially since she felt she was inexperienced and did not really know what questions to ask the care provider. Mrs. C felt that if care providers gave “good” advice, advice that she could relate to, she was more apt to follow the suggestions offered for a healthy pregnancy and childbearing. She defined the ability for her to relate meant that she knew the advice was given with the understanding and empathy for her lifestyle. If she did not like the advice they gave and it did not make sense to her or fit into her lifestyle, then she would not use it, but she would be kind in her rejection.

She has enjoyed having an Amish midwife during her childbearing, but liked having a trained care provider present as well in case of emergencies. She felt that Amish midwives did have an advantage because they are more knowledgeable about Amish ways, which was helpful. If an English midwife was knowledgeable about Amish ways, then they could better understand what her life was like. Similar to my experience with Mrs. A and Mrs. B, Mrs. C prefers a more natural approach to childbearing, and also one that is safe and low cost.

Mrs. C said she generally would seek a check-up when she was past the time for her menses and thought she may be pregnant. She appreciated having a care provider who would listen and allow her to use herbs and natural remedies during childbearing. She also felt that mutual trust between the care provider and herself was very important. She prefers not to be forced to do things, but likes for the care provider to explain why certain things may be indicated and why they had worked with other women.

### **Research Question 3/Theme 3**

Mrs. C felt her comfort level was increased if the care provider was Amish, because it is easier for them to understand her Amish ways. She liked knowing them,

having the ability to go to church together, and felt the fact they both were part of a close community made it easier to be comfortable at delivery time. It was comforting to her during childbearing to have someone helping who knew her well and understood how she thought, this kinship and camaraderie was important to her. Mrs. C felt that Amish midwives are much less expensive than going to the hospital, and are not likely to use drugs which could harm the baby or mother. This was an important factor in the healing process in her impression. She felt that doing things the natural way and using natural means for healing are important in the Amish culture.

Mrs. C felt the Amish midwife's approach is a more natural and comfortable approach than traditional English care providers. Mrs. C said that if an English care provider showed sensitivity and understanding of her Amish ways it would make a difference in her trust of them. If they listened and empathized with her lifestyle, it would show caring to her. One way she felt midwives could nurture Amish women and show caring to the Amish community would be to practice in her area and minister to the women in their homes alongside the Amish midwife. She said Amish women would feel much more comfortable to be seen in their own homes; it would be more relaxing and less of a threat to their way of life.

#### Assertion

The last set of interview questions (21-34) that were directly related to the Servant-Leadership characteristics seemed to have value for Mrs. C. She was personally able to relate to many of the attributes. Mrs. C voiced appreciation in care providers who want to build a trusting relationship and take the time to do that. Mrs. C felt that some of these characteristics are principles that align with her Amish beliefs and help her

consistently uphold a life of faith; the same principles that she felt had been handed down from the Amish forefathers. Mrs. C also plans to teach her young son much the same way her parents taught her; to respect principles such as listening carefully to others so as to be obedient, to show humility to others' opinions, and to be empathetic by accepting others and recognizing their value. Mrs. C has a little brother who has Down Syndrome, and as a result she especially values those who see beyond disabilities and see the blessings of all special children.

Practicing right-living is one of the tenets of the Amish ways, according to Mrs. C. The ability to help others like using simple healing practices, showing awareness for others needs, and using gentle persuasion rather than coercion when explaining things, nurturing others in their hopes, and handing down wisdom from generation to generation are considered "right-living." Mrs. C believes in her opinion that the Amish see right-living as living a redemptive life so that you are a good member of society and can seek to serve others in your family and community. Mrs. C felt that helping others to grow in life and adding to their happiness is what God requires of us and what makes us happy. She felt it would be easier to relate to someone who had the same values in these areas.

#### Triangulation Source for Assertion

I also spent time visiting with an actively practicing Amish midwife in this Amish community. She was a grandmother many times over and had lots of great stories and folk remedies that she was willing to share. I was interested to see if she might have other opinions in which to triangulate the information I had received from Mrs. C. Mrs. C had voiced strong feelings about the need to have an Amish midwife. I was interested in knowing from this Amish midwife, her perspective on how she felt about utilizing



non-Amish health care providers in Amish communities and what she thought was important for English care providers to know about their culture when working with Amish childbearing women.

This experience proved interesting and significant in terms of talking with another source that may have a totally different opinion and may not be accepting of having English help since she had a thriving practice of her own and was well respected among her own Amish community. This 59-year-old energetic mother of 10 and grandmother of 34 still was actively practicing and enjoying being the primary midwife of the surrounding Amish communities. She had 17 pregnancies herself, 6 of which ended in miscarriage. One of her children also died as an infant from complications of dwarfism, and a grandson with the same diagnosis is not doing well. She uses herbs extensively in her midwifery practice, and readily admits that the Amish women prefer more natural ways; it is their heritage based on the concept that God's ways are the most natural. We discussed the many herbs she uses, and she got out her herb books and even gave me some to take home. We exchanged midwifery stories and ways we control certain obstetrical emergencies.

I found her to be very candid and not shy at voicing her opinions. She felt her most important role was keeping the environment calm for her clients, and that being Amish helped her to do that best since she understood their ways. I could not argue with that, so I asked, "What if an English care provider tried very hard to understand the Amish ways . . . could they be effective if there were no other options for the Amish women?" She thought that Amish birth centers might be okay in some areas if owned by the Amish, and if the English understood the Amish ways.

She felt that English care providers were too quick to do medical interventions when there were many natural ways to deal with situations such as turning breech babies and controlling bleeding, increasing milk production and slowing down early labor or getting labor started when the mother was overdue. She advocated massage during the entire pregnancy. She truly was a wealth of information, and had years of experience to support her findings. She also affirmed that being a good listener and being sensitive to the needs of your client are important. Building trust with the childbearing woman by taking time to listen to her concerns and staying aware of what is happening in the childbearing woman's environment is crucial to having a positive childbearing experience.

I sensed by the midwife's comments and body language that she was not fully convinced that English midwives could ever really understand Amish ways. She did voice that progress could be made if they would put forth the effort to learn about Amish ways and be willing to be sensitive to Amish beliefs and practices. Being the take-charge kind of person that she appeared to be, I found it interesting to hear her voice how important it is that the environment for Amish childbearing women must be very relaxed and calm for birth to be positive. Her concern that the Amish women have safe and adequate care that was not costly and was sensitive to their Amish beliefs was her prime concern.

It occurred to me after the interview during reflection that there may be hope in utilizing a Servant-Leadership model of caring since the main constructs were about creating an atmosphere of trust and breaking down any misunderstandings that may occur. The principles behind Servant-Leadership may offer a way to create the relaxing

and calm atmosphere that this Amish midwife endorsed. More importantly, I sensed a vision to capture a culture of care that the Amish midwife desired for her clients.

#### **Case Study 4**

##### **Entry Vignette: Background**

Mrs. D is a 40-year-old Amish woman who has been a friend and client of the physician gatekeeper for this study. The gatekeeper had attended several of the deliveries of Mrs. D's nine children. Mrs. D describes her children with a smile which she accentuates with little bursts of laughter. She also clearly remembers each child's birth weight, birth date, and birth story. She looked sad however when she spoke of her little girl, H who had died in a tragic accident at age 10. H had cerebral palsy (CP) and was deaf after contracting rubella at 2 months of age; the Amish do not generally vaccinate their children as they are concerned about side effects and the additives used in the preparations. At the time of the initial interview Mrs. D's living children were 18, 16, 14, 11, 8, 6, 4, 2 and 8 weeks. Her oldest child was born in a hospital, while the rest were delivered at home with midwives and the gatekeeper physician in attendance. Mrs. D attended Amish schools up through eighth grade in Ohio, and currently lives in the area with her husband of 20 years.

Mrs. D uses herbs and supplements such as cell-wise, calcium, and multivitamins, red raspberry, alfalfa, and nettle on a regular basis during pregnancy. She worked outside her home as a mother's helper for other Amish families when she was younger, and did housecleaning for English families. She enjoys reading Amish magazines such as *The Budget*, *Plain Interest*, *The Diary*, and *Old Country News*, as well as her German Bible.

## Issue Development

### **Research Question 1/Theme 1**

Mrs. D, elaborating on the questions used for discussion points, shared that health to her meant feeling good so she could do her work, which was very important since she also has a big family. Healthy childbearing meant to her having a healthy baby and feeling good during her pregnancy. When she was younger and not as experienced, she depended more on the women in her family, especially her sister-in-law, to give her advice on childbearing and what she needed to do. Some of the advice she received from her family members and other Amish women in her church were to use lots of fruits and vegetables, rest when she could, and not to overdo on heavy chores but to have her husband help. She also used certain herbs and visited a natural healer for chiropractic massage. She felt that the experiences she had during childbearing were meaningful, and now was comfortable enough in the childbearing processes that she could help others. Her beliefs and practices had matured over time, and they were an important part of her life.

### **Research Question 2/Theme 2**

Mrs. D thinks that it is very important for care providers to be sensitive to the fact that she may want to ask questions and not just have the care provider give her information. For instance, care providers should really listen to what she is saying and care about what is happening to her from her perspective and history. She always appreciated having a care provider who was warm and caring, and who took extra time to let her ask questions. She enjoys having Amish midwives to care for her, and feels they have an advantage because they have more knowledge about Amish ways. This extra

knowledge was helpful, but when the physician friend was in town, Mrs. D enjoyed having her present for added security. If an English midwife were knowledgeable about Amish ways, they could understand better what her life was like and it would be easier for them to be empathetic like the gatekeeper. Such a midwife would recognize the value and uniqueness of Amish ways, and plan interventions that were respectful of those ways.

### **Research Question 3/Theme 3**

Mrs. D felt that if care providers gave good advice she could relate to, and made suggestions that fit into her lifestyle, then she was more apt to apply the suggestions they made for a healthy pregnancy and childbearing. She preferred not to be forced to do things, but for a care provider to explain why actions may be indicated. She appreciated advice from those who understood her ways, understood a simple life of obedience, submission, and caring. If she did not like the advice they gave, and it did not make sense to her, then she would not use it.

Mrs. D, like the other Amish women interviewed, preferred a more natural approach to childbearing. She generally would seek a check-up when she was 3 or 4 months pregnant, as long as everything seemed okay. She also felt that trust between the care provider and patient was very important in having a good partnership during childbearing. She liked working together on outcomes.

Mrs. D validated that the principles discussed in section 3 of the interview (the characteristics of Servant-Leadership) helped develop meaningful partnerships between the care provider and the Amish woman. A care provider who consistently listened and strived to understand from the client's perspective would have a better chance at building a trusting relationship. She went on to intimate that care providers who were aware of the

simple and natural ways of healing, and of the dislike Amish women feel for having things “lorded over” them, would be more successful in building trust.

#### Assertion

Mrs. D felt that the principles mentioned in the last section of the interview questions also were principles of the *ordnung*, which her family had passed down to her. Seeking to use the wisdom of the past to help make future decisions, and nurturing others in whatever walk they chose, helped to serve others generously and with understanding. These principles in themselves helped build commitment and community not only in the church, but in other relationships as well. She described how she is trying to teach her children these principles by example, and by using illustrations that were applicable to their reasoning abilities.

#### Triangulation Source for Assertion

I was able to discuss with Dr. Karon Schwartz my observations and the candid responses from the participants in this study. We discussed how some of the findings in her study were affirmed in this study. Dr. Schwartz improved nursing practice by demonstrating that health care to the Amish should acknowledge their culturally oriented beliefs and practices in order to be effective. She was excited to know how the Servant-Leadership model could be congruent with Amish ways. We had talked together back two years before and she had encouraged me to consider pursuing my research hunch that Servant-Leadership characteristics may help in building trust and providing culturally congruent care to the Amish childbearing women.

She affirmed that the responses of the participants in this study certainly supported her findings in several key issues, namely, that God's will is seen in all things, health is a resource to do your daily work, natural ways are God's ways, commitment to family and community are over-arching values, culturally congruent care decreases misunderstandings and builds trust, the Amish are more open to education and interventions if there is trust, and that care providers are more accepted if they are congenial and open, non-condescending, and non-critical of the Amish culture. Her knowledge of the Amish, based on her research, many years spent working among the Amish, and having in-laws who are Amish, has given her many insights and compassion for this ethno-cultural community (K.S. Schwartz, personal communication, September 21, 2005).

### **Case Study 5**

#### **Entry Vignette: Background**

Mrs. E, a 48-year-old Amish woman who shared an incredible story of faith and courage, is a close friend of the gatekeeper. The gatekeeper physician had been with her during several of her deliveries, and has assisted her in getting help for her seven children with cystic fibrosis. There is obvious devotion when Mrs. E speaks of her 15 pregnancies and subsequent childbirth experiences. She has had seven precious children with cystic fibrosis, five of whom have died and two who are undergoing intensive therapy for their disease. Mrs. E's last child, born in 2003, was a stillborn; she also had lost one other child through early pregnancy loss.

This mother's brave and sweet spirit touched my heart. She and her husband of 29+ years have a keen understanding of what it means to have a strong faith and

appreciation of each day, seeing life as a tentative but precious trust. They both have cystic fibrosis in their bloodlines and feel strongly that God gives us blessings in everyday life, sometimes in the gift of a sick child. In fact, she feels that every situation contains a lesson of love, even if we do not understand it at the time. She shared that there are many blessings and gifts around you even in times of sadness; gifts such as faith and love can only come from God. Allowing God to help her in the trials of life gave life meaning, and instilled in her a longing for His better place. Mrs. E said His life and goodness are what give us hope; trusting in Him gave her the victory to live a redemptive life and is what gives joy and meaning to her life here on Earth while she waits for His return.

Mrs. E helps her son in his basket-weaving business. This special son has cystic fibrosis (CF) and often is not able to run his business, though it is located just outside the house. She is aware that the business gives him independence and added joy in the knowledge that he is contributing his share for expenses. Mrs. E also worked hard cleaning English homes before her marriage. She feels that helping her son to establish a trade will give him the encouragement he needs as he creates beautiful objects with his hands. He does not seem to dwell on his illness, and the times I visited with him he was cheerful, outgoing and seemed happy to show me his crafts. "What a wise mother," I thought, "to help her sick children live as normal and enduring a life as they can in the short time they have." Even the youngest little boy with CF was expected to help with chores, and play outside with his siblings when he was not sick.

Mrs. E also enjoyed reading Amish and English books such as *Birds and Blooms* or morally uplifting story books to the children. She reads the German Bible as well, and



seemed well versed in matters of agriculture and nature. She cheerfully pointed out to me the many bird feeders and the variety of beautiful birds in her yard. She enjoyed having the children learn from the birds and understand their responsibility in taking care of God's animals. She shared a book that she has compiled containing many interesting remedies, recipes, and everyday household practical applications. I was very impressed with her broad knowledge base and entrepreneurial spirit. She ran her household like a well-run business and sold some commodities to the community as well, such as fresh maple syrup.

### Issue Development

#### **Research Question 1/Theme 1**

Mrs. E's definition of what health means was transformational for me. She explained, as only a mother who has suffered could, that health could easily be taken for granted. She felt it was a real mistake to allow that to happen, as it is the simple things that bring so much meaning to our lives. She went on to describe the ability to rock and hold your babies one more day, saying that is what health is about. Feeling good is important so you can care for your family, work in God's gardens, and watch both grow. Healthy childbearing is feeling good as you carry this life within you and bring a healthy baby into the world. Even the special children, she explained, bring happiness.

Mrs. E believes that using the simple remedies and herbs is good during pregnancy, and she uses these as much as possible. She also values more traditional medicines and treatments for the help they have brought her children, believing God has ordained these as well.

### **Research Question 2/Theme 2**

Mrs. E has appreciated having care providers who not only took time to listen, but invested in building a trusting relationship by being caring, showing empathy and awareness, and offering support rather than censure. She valued those care providers who had the foresight to help her plan for the care of her children, and help her seek to nurture them in their journey even if it was a short one (6 of her children died before age 3). She believes that care providers have the ability to hold their work of healing up as betterment for society, but this requires the commitment to unselfishly help others. Such concepts of caring are congruent with her Amish beliefs and practices; she herself tries to live out these principles daily and hold in trust her ability in some small way to make a difference in the lives of her children, her family, and her community.

### **Research Question 3/Theme 3**

Mrs. E commented that all the principles listed in the last section of the research interview questions had relevance for her life as an Amish childbearing woman, but also for care providers who want to give sensitive and compassionate care to Amish childbearing women. Her perceptions of these concept-of-caring principles might resemble the following: These are penned from her descriptions, our conversations, and her life story as I listened, learned, asked questions, observed, and took notes.

1. Perform active listening from the heart; may your caring be such that it is expressed by extending yourself for others' problems (empathy).
2. Holistic healing means taking care of the soul as well as the body.
3. Demonstrating understanding for another's issues (awareness) means laying your own personal issues aside.

4. Gently leading (persuasion) is never about forcing your way upon another but being willing to give up your ideas to join in the journey with another (conceptualization).

5. Take time to share your stories (lifeways) to help another (foresight). They are your stories but they were not meant to be hidden but to give light.

6. Value others (stewardship). We all are here to help and encourage each another.

7. Take personal interest in the life-ways of others (commitment to the growth of people). In this you will find true joy.

8. Serving is about living your life in a generous and unselfish way so as to be a blessing to others (building community).

Mrs. E shared how one of the doctors who helped so much over the years to take care of her children has demonstrated many of these principles. His kindness and true concern for her family have empowered her to try and do the same; his love manifested towards them made a difference.

#### Assertion

Mrs. E illustrated how the principles she lives by are congruent with the Servant-Leadership characteristics. Her personal commitments to the Amish faith and to God are principles that she has been taught from the *ordnung* concepts handed down from her parents. She shares these lessons of faith with her children through example. The *ordnung* is not mentioned specifically with her small children it is more that the principles are lived out in the home. That was how she was taught the principles as well.

The children will be made aware of the principles verbally when they are ready for baptism as an adult. Daily devotions from the prayer book, both morning and night, help to solidify these concepts in the children's young minds. Her husband reads mostly from the German Bible to the children on Sundays. They try to provide a home that is warm with love and acceptance. Mrs. E asserted that if care providers give Amish women childbearing care that is based on understanding these beliefs and principles, the relationship will be one that is beneficial and of lasting significance to both the care provider and the client.

#### Triangulation Source for Assertion

Spears and Lawrence (2002) challenged leaders to practice Servant-Leadership; to create a quiet revolution in workplaces around the world. I recently was able to share with Mr. Larry Spears, CEO of the Greenleaf Center for Servant-Leadership, the findings in this study; how the 10 guiding principles of Servant-Leadership were prescriptive of caring and transformational in practice. We had agreed a year ago that when I had completed my data collecting that he would like to hear how things had gone. He agreed that the dignity of the human spirit is affirmed by these principles and that was why Mr. Robert Greenleaf himself, with Anabaptist roots, was influenced and transformed by these Biblical and humanitarian concepts (L. Spears, personal communication, September 19, 2005).

## Case Study 6

### Entry Vignette: Background

Mrs. F is a 62-year-old Amish woman who is a retired Amish midwife. The gatekeeper and Mrs. F are friends and have worked together for many years, supporting each other through childbearing experiences. Mrs. F was eager to talk with me about her midwifery experiences, and I was delighted to have her share her thoughts and feelings concerning Amish childbearing beliefs and practices.

She described her midwifery experiences with a sparkle in her eyes that spoke of her enjoyment of the art. She, along with her husband of 41 years, has lived and practiced midwifery for the Amish for over 20 years. Prior to her work as a midwife in that area, Mrs. F worked with her mother among the Amish families in Ohio many years. Mrs. F has had three children of her own, and also has suffered the tragedy of pregnancy loss as well. We spent considerable time discussing the many herbs she uses with Amish childbearing families. These include herbs for labor stimulation, milk production, increased bleeding, uterine support, female cycles, anemia, and overall support of the immune system.

Mrs. F. enjoys reading *The Budget*, *The Diary*, an assortment of herb books and catalogs, *Country, Farm and Ranch*, and her German Bible. Her own tragic buggy accident 2 years ago left her crippled in her legs and unable to do the work she loves because of her many physical limitations. Tears come readily to her eyes as she describes the stories of her past, and her inability now to help others with the birthing of their children.

## Issue Development

### Research Question 1/Theme 1

Mrs. F felt that health to her meant feeling good so she could do her work; the main thing for the day is being able to get up and feel good. She elaborated on how a healthy pregnancy is something we can never thank God enough for. For her healthy childbearing meant feeling well so you could care for your family and help others in need. She shared that she has enjoyed both roles, as a mother, now a grandmother, and as an Amish midwife. Mrs. F also thought it was important to use pregnancy herbs to support a healthy pregnancy. She felt it is very important for care providers to be sensitive to their client's needs and to create a relaxed and calming environment. For instance, really listening to what the pregnant woman is saying, and caring about what is happening to her. Mrs. F said she always appreciated having, and being, a care provider who exuded warmth and caring and took extra time to create a supportive environment for clients. She feels that Amish midwives have an advantage when caring for other Amish women, because they have more knowledge about Amish ways.

If an English midwife was knowledgeable about Amish ways, she could better understand the needs of her Amish clients. Mrs. F felt that if care providers gave good, practical advice and made suggestions that fit into their client's lifestyle, then they would have an easier time with their clients being accepting of their interventions. If Amish clients did not like the advice, and it did not make sense to them, they certainly would not follow it. She felt this was an especially true principle in Amish families because Amish women are very busy caring for their generally large families and have no time for things that do not make sense to them or are not seen as practical. She explained why Amish

women prefer a more natural approach to childbearing: they feel it is safer, more cost-effective, and most in line with their world views because “God’s ways are natural!”

Mrs. F generally would encourage her clients to seek a check-up when they had missed their period, unless they were more experienced in childbearing and if everything was okay. She felt that when you are in your prime and healthy, it is fine to use lay midwives and have your babies at home. Having more information on healthy childbearing was considered a good thing, as long as it was practical knowledge.

Mrs. F’s enjoyment of working as a midwife was contagious, and it was obvious how much she listened to and respected the women under her care. She continues to read when she is feeling well. It was really sad to see how she had deteriorated in just 12 months’ time between visits. She saw the value in providing a safe and relaxing environment where Amish women could safely give birth in their homes. She felt that providing a natural way for healing and birth is the Amish way, and believes that God has given us many natural things for healing as a first preference.

## **Research Question 2/Theme 2**

Mrs. F. also feels that developing trust between the care provider and the patient is important. She advocates that this trust is often developed by being a servant giver, one who takes all the time necessary to give presence to your client. This might mean just listening for as long as it takes to give her the necessary confidence in you that she needs. She shared that none of us like to be forced or to force others to do things. Mrs. F believes in providing encouragement and sound explanations as to why things might need to be done in a different way at times. Trust is built if the care provider takes the time to try to understand her client’s needs, since they are ever changing. Mrs. F saw her job as a

ministry or a gift that God had given her to help her people. With tears, she regrets that she can no longer do midwifery. If other midwives could gain information on how to build trust with their Amish patients through this study, she felt it would be a very good thing.

Caring constructs were identified as those characteristics that allowed the care provider means to show sensitivity to your clients' beliefs and practices by trying to understand their lifestyle and realizing the importance their beliefs hold in their lives. One way she felt nurse midwives could nurture the women in the Amish community and demonstrate sensitivity to their culture was to continue to become knowledgeable about their ways. She felt it would make the Amish women much more comfortable and supportive of building trusting relationships with non-Amish care providers.

### **Research Question 3/Theme 3**

Principles of strength, for Mrs. F were shaped by the belief that all things come from God and are subject to His will. Mrs. F. saw each child as a gift from God and valued. Loving and caring for her grandchildren and others when she was able was about commitment to the growth of others. Health means being able to do your work and caring for others (but especially your family) and is God's way. Simple ways are best; a more natural approach to health is God's way. Obedience, being humble, right living, submission, and self-sacrifice for others all are a part of the commitment to God in living a redemptive life. These were principles of strength for her.

Mrs. F's summary of what she felt were the important characteristics that should be emulated by care providers and have helped her give culture care to Amish childbearing women are similar to the Servant-Leadership characteristics. The



characteristics were listening, being empathetic, being aware of others' needs and actively doing things to take care of those needs, gently encouraging, planning care that is meaningful for the individual, caring holistically about others, using folk healing as needed, building relationships in the community by showing humility and self-sacrifice and hard work.

#### Assertion

Mrs. F affirmed Amish beliefs and practices were important to her and are practiced throughout childbearing. According to Mrs. F, it would be helpful if the care provider incorporated as many Amish beliefs and practices as possible when planning the care plan during childbearing. The Amish beliefs and practices aligned well with the Servant-Leadership characteristics. Mrs. F affirmed that being a good listener, showing concern and empathy, and accommodating healing practices that are valued by the client are important characteristics for the health care provider to have.

Other important practices, such as being understanding and showing awareness of the needs of your clients, will help build trust in the relationship. Also, using gentle persuasion, conceptualizing how to accommodate your client's cultural practices and using foresight to learn from mistakes and being willing to share those mistakes makes the care provider more human and approachable. Working for the greater good of others meant being committed to helping your clients be all they can be. Remaining focused on creating trusting relationships and special lasting birthing memories was important to Mrs. F and she felt should also be important to any caring health care provider.

The Amish-held beliefs and practices were easily accommodated by the closely aligned characteristics of the Servant-Leadership model. Mrs. F and her husband always

made me feel very welcome and lived out these principles in their daily lives. Even with their setbacks financially, they always wanted to give me a handmade gift. I will always treasure their generosity and kindness toward this English research student who gained so much in my understanding of humility and was blessed by just spending time with them.

#### Triangulation Source for Assertion

I now understand what Mason (2002) articulated so well in his recommendations section of his dissertation. The final and most noteworthy aspect of the Servant-Leadership model is that we need to be true to the admonition that we love our neighbor as we love ourselves; it really is about loving our fellow-human beings, and extending one's self for another.

Dr. Mason recently was honored with the Humanitarian award by the National Conference of Christians and Jews. He is known for practicing Servant-Leadership principles throughout his life. I recently discussed my research study and findings with him in a phone call since he has graciously encouraged me in this pursuit and even sent me his full dissertation to read once he knew of my interest in Servant-Leadership and health care. I wanted to get his opinion on my findings and have him confirm or deny the potential for transferability to other disciplines, particularly since he has spent many years in service to other cultures. He was very affirming of my applications, and felt that the 10 guiding principles did provide a theoretical and ethical basis for providing a culture of care and compassion that was congruent with the Amish ways. He also felt that these principles are transferable to many different settings due to the nature of the model and how such concepts of caring are relevant for all peoples who treasure being loved (W.C. Mason, personal communication, September 19, 2005).

## Case Study 7

### Entry Vignette: Background

Mrs. G is a 49-year-old Amish woman with a vibrant personality. She and the gatekeeper physician have a trusting relationship built through many years of working together both in a care provider/client relationship and as friends helping each other. Mrs. G has lived in the area and Amish community for 24 years. She and her husband have a woodworking and craft business in a building next to their home. They also have 10 living children from her 14 pregnancies. Her miscarriages all were the result of early pregnancy losses.

Mrs. G's oldest child has a brain disorder and CP, and her youngest, a very loving and affectionate child, has Down syndrome. She sees each child as a very special gift from God and enjoys her children immensely. She and her husband have been married 29 years and had their first baby the year after they were married. Mrs. G runs her home in a very efficient manner, with strict meal times and chores. She impressed me with the orderliness and organization of her home. The children seemed to enjoy the structure, and seemed proud of their accomplishments. Even the children with special needs had their assigned jobs, and attended the Amish school with the others. There are no provisions in the Amish schools for special needs, and Mrs. G expressed that she wishes there were. It would make learning easier and less frustrating for children with disabilities. She shared her excitement about the current discussions within the Amish community about starting such a program.

Mrs. G has had a variety of care providers during childbearing, and felt she could thus speak from experience when comparing options. Mrs. G enjoys the entrepreneurial

aspects of their Amish craft business and is also an avid reader. She enjoys reading Amish and non-Amish literature; some of her favorites are *Country Magazine*, *The Budget*, *Bodshoft*, *Farm and Ranch*, books on herbs, botanical magazines, and the German Bible.

### Issue Development

#### Research Question 1/Theme 1

Mrs. G felt that the ethno-beliefs and practices of the Amish definitely impact their childbearing care. Each child is seen as a gift from God, and healthy childbearing means feeling well enough to care for your family without having to hire a mother's helper. She felt that the non-Amish care providers she had in the past were most effective if they understood the Amish culture and ways. Childbearing is viewed as a natural phenomenon, not a medical condition. Natural ways are most appreciated, but there are times when medical interventions are needed and desired. In the case of her youngest, it was imperative that her little girl have heart surgery. Mrs. G and her husband have been grateful that they had the operation done as their daughter has done fairly well since her surgery.

Mrs. G also felt that it was fine to use lay midwives when you were young and healthy, although she always felt better when her physician friend could be there for support as well. She was comfortable with suggestions for health care if they were practical and did not go against her belief system or values. She felt she was open to suggestions of well-informed care providers. She does feel that God has given us many natural ways to treat, and these should be used as a first preference. She consistently uses

herbs and natural remedies, along with chiropractic manipulations by an Amish healer as a form of physical therapy for herself and her family.

### **Research Question 2/Theme 2**

Mrs. G values the ability of a care provider who wants to be a good listener and who respects the client's choices concerning health care management. She appreciates not being coerced, but being challenged to think things out reasonably. Empathy and awareness go far in connecting with each other, even in a health care partnership. She has, for the most part, had good relationships with her care providers, and felt an important key to such a relationship was open and honest communication practices. If the care provider takes the time and effort to conceptualize the beliefs and practices of their client's culture into a care plan, then there is a better chance of working well together. Committing to serve others as a ministry of caring benefits everyone involved.

Sharing knowledge is one way Mrs. G feels she can help to serve others; I was the second student whom she had allowed to interview regarding her Amish beliefs and practices related to health care. Both her open-mindedness and her desire to help open channels of understanding were to be commended. She felt her parents and community had passed down important tenets of faith and understanding to her, and she was more than willing to pass on knowledge as well in order to help others.

Mrs. G's wonderful charisma and enjoyment of other people from all walks of life are probably why the business she runs with her husband has thrived. Many English come to trade at her store. I am still in wonderment as to how she kept everything running so smoothly and effortlessly with 10 children, a home to run, and a business as well. She

described her bond with her family and other fellow Amish as being an important support network, and stated that her faith in God is what carries her through each day.

### **Research Question 3/Theme 3**

Mrs. G felt that the unwritten principles of the *ordnung* include many of the characteristics of the Servant-Leadership model. Even though she did not know what the characteristics were since they were hidden within the framework of the questions, she identified with the principles of the 10 characteristics as outlined in the interview questions. She affirmed the principles as being important to her and also being important for the health care giver to have in order to give meaningful care to the childbearing woman. She conceptualized these principles in her own life as often as possible. She was a wonderful example of Greenleaf's (1977) concept that a Servant-Leader is servant first, and has a natural desire to serve others. She also set an example in Servant-Leadership caring in that those she is serving become healthier, wiser, freer, more autonomous, and more likely to become servants themselves.

### **Assertion**

She affirmed that the ethno-beliefs of Amish women do affect their health care during childbearing. She affirmed in her own way that the 10 characteristics of the Servant-Leadership model were an important aspect of Amish ways, and the congruency was shown in the caring and unselfish way that she lived to serve others. Her influence as a Servant-Leader is obvious to the many Amish and English she serves. I am one example of her generosity and unselfish serving and sharing; she has inspired me to

become healthier, wiser, freer, more autonomous, and a humble and caring servant of humanity in any way I can.

#### Triangulation Source for Assertion

The last source I want to mention in reference to this vignette is Patty Barnes who has been a Servant-Leader care provider to the Amish for more than 17 years. I talked with her concerning my observations and findings and asked her to critique them as an additional expert source on Old Order Amish culture. Barnes was excited; she is a professional, certified midwife herself, and assists her husband in putting out a circular subscribed to by over 1,000 Amish. She lives and practices within an Amish community, value their lifeways, and assist them in any way she can.

Ms. Barnes expressed excitement over the 10 principles being used as a model to improve communication, decrease misunderstandings, and build trust between English care providers and Amish families. She affirmed the findings of what the Amish childbearing beliefs and practices were found to be, and the implications those findings had for care providers. She shared that recently, since her husband's accident that has put him out of work, she has been overwhelmed by the love, compassion, and help that her Amish and Mennonite community has given her family. The Amish recently put a new roof on their house, and are involved in taking on some of her husband's chores that he can no longer do.

Ms. Barnes concluded that she has incorporated many of the principles in her own practice over the years, and felt the practice had built strong relationships of trust and partnerships with the Amish families. She laughingly shared that she feels so accepted by the Amish women that they make her head coverings and like to see her wear them. They

also love to teach her the German Dutch so she can use their expressions. She has so many interesting and special stories of connection and mutual sharing to tell; stories about both herself and the Amish women she serves. She felt to build trust between two diverse cultures is a noble one; a desired goal worth seeking if culturally congruent care is to occur (P. Barnes, personal communication, September 22, 2005).

### **Summary**

In summarizing chapter 4 the art of “found poetry” will be used. Found poetry begins life as passages of expository prose. The purpose is to give voice from the participants to the reader. Those forms, or concepts of life, are best portrayed by poetry because it transcends the limits of plain language and adds an art form of understanding that can stand alone in a relatively small amount of space and time (Richardson, 1990). The poem was inspired by the women’s sharing of their narratives in my study; from interpretations of narratives by Amish writers and non-Amish writers concerning Amish women, as well as their own prose and my interpretations. I use this form of alternative data representation both to demonstrate the richness that is so apparent in the telling of their narratives and the connectivity between the guiding principles of Servant-Leadership and Amish women’s ethno-cultural beliefs.

### **Amish Beauty**

Please listen  
 My story has a deeper meaning  
 If you will pause for a moment and  
 Just listen  
 Because you asked, I will tell you  
 My journey is far away perhaps from yours in many ways  
 But similar in others  
 I enjoy my world of buggies, of beautiful growing babies who go  
 Barefoot along the dirt roads and wild flowers  
 Who get lost in the loveliness of a wild meadow or



The soft furs of the many family farm pets.  
 The journey has required no less from me  
 Than to learn to have tolerance for the simple joys in life  
     Like the art of listening,  
     The healing touch of empathy,  
     The healing of relationships,  
     The patient world of awareness,  
     The gentle rain of persuasion vs. coercion,  
 The credence of understanding another's plight  
     And trying hard to understand,  
 The foresight of reflection because this is where the soul lives,  
 The unassuming but wonderfully "güt gift" of stewardship  
     Toward all of God's creatures.  
 The encouragement of commitment because that  
     Is what faith is all about--  
     Life is shaped by this faith  
         a gift from God.  
 His ways are best, the simple and natural ways  
     The pathway to obedience  
     Humility and right living  
 Are acceptances that the mightiest of rivers is  
     First fed by many small streams  
     My sense of community is who I am  
 It inspires me to a life of submission and self-sacrifice  
     This is my part in giving back, in living  
     With God's help a redemptive life.  
 May your journey be a blessed one like mine  
 May you understand, reflect, enjoy, laugh, cry and  
 Be touched by the many facets of life that bring completion  
 And greater understanding into why we are really here.  
 The Grace of great things is the humility we feel  
     When we truly experience another's soul  
 Because they felt free and safe to share and we  
     Felt love enough to embrace the gift  
         This is my journey  
 It leads me to a valley of peace in all things  
     As His will be done!

In conclusion, chapter 4 has allowed the reader to consider the knowledge  
 presented in each case. The case study method conceptually supported the information  
 pertaining to the issues of development that answered the three research questions. First,  
 how did the ethno-cultural beliefs of Amish women influence their health care in

childbearing? Second, was there congruence between the Servant-Leadership model and Amish childbearing women's ethno-cultural beliefs? Third, what were the culturally congruent guiding principles that could assist care providers in giving culturally sensitive care to Amish childbearing women?

First, cultural beliefs were viewed as being important and practiced during childbearing by the Amish women. Second, concepts of caring are part of the culture of caring and need to be included in the plan of care if the interventions are to be meaningful and adapted by the Amish childbearing woman. Third, congruent principles need to be used by the nurse-midwife or childbearing provider for culturally sensitive care to the Amish childbearing woman to occur. Implications of the confluence of relationship between the three research questions and the three themes that emerged will be discussed in the Implications section in chapter 5.

## CHAPTER 5

### SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

#### **Introduction**

The overall purpose of this study was to explore the health care beliefs and practices of Amish women related to childbearing, and how nurse-midwives as Servant-Leaders may gain insight for the teaching and promotion of health care among Amish women. Utilizing the 10 guiding principles of Servant-Leadership as a theoretical model for giving culturally congruent care to Amish childbearing women opened up opportunities for research exploration.

My interest in exploring Amish childbearing beliefs and practices and the implications for nurse-midwives as Servant-Leaders began when I was a clinical instructor taking nursing students to an Amish birth center. Later, as I was involved directly in making childbearing and well-woman visits in Amish homes with another nurse-midwife care provider, circumstances arose that created some misunderstandings from a cultural perspective. I became convinced that a traditional approach to understanding the essence of why and how Amish childbearing women subscribed to certain aspects of care and not to others would be insufficient. A care provider would need to explore the health care beliefs and practices from the Amish women themselves, from their own cultural perspective.

An ethnographic approach would allow exploration from within their cultural setting; capturing the Amish women's life and relationships as they truly are and not as they are perceived by those outside the community. I personally wanted to be a more culturally sensitive care provider and make a difference in the lives of the clients I served. As I studied Leadership theory and taught Leadership classes to nursing students, I was convicted that Servant-Leadership theory was the essence of creating a pedagogy of trust. Trust begins with culture-caring motives, being sensitive to the mental programming (beliefs) that individuals in cultures hold to be true.

To serve my Amish clients in a manner that ensures their highest priority needs are being met, and while being served, they become healthier, wiser, freer, and more autonomous—what Greenleaf (1977) postulates constitutes true Servant-Leadership—was my desire. I also wanted to take one of the hallmarks of nurse-midwifery practice, client education, to a deeper understanding of inquiry for those of us seeking to give culturally congruent care. I believed that identifying the caring attributes that Amish childbearing women subscribe to would open the way for nurse-midwives and other care providers to make an impact on Amish women's childbearing experiences from a culturally congruent perspective.

I wanted to uncover the Amish women's meaning of their lived experiences from their perspective about childbearing as it applies to their health care beliefs and practices. I also wanted to determine what they felt was important in terms of their education and facilitation of knowledge. This experience helped identify the health care reasoning and choices of Amish women during childbearing from their own perspective, as well as the care provider's role in facilitating such education from a culturally congruent perspective.

## **Methodology**

Gaining intimate knowledge of lifestyles and beliefs from a holistic perspective required a cultural sharing model of research. Using an ethnographic approach for data collection facilitated discovery of the rich cultural meanings that would have been difficult to describe employing a non-qualitative method. Ethnographic design gave me a meaningful way to experience and describe multiple representations, and to capture the beauty of expression and perception in a variety of ways. I found collecting and analyzing the data using a Servant-Leadership model not only helpful, but also valuable in terms of a cultural awareness of Amish beliefs and practices. Not only is qualitative inquiry complex, evolving, historical, and creatively challenging in terms of reflective inquiry, it provided me with a way to communicate my willingness to truly listen and understand the narrative of each woman.

Utilizing Servant-Leadership principles for assessing the data in my research aided in the ability to have meaningful findings. Employing the Servant-Leadership model helped me to analyze my methods for verity, integrity, and authenticity. This practice of Servant-Leadership gave me a deeper understanding of how time-consuming research data is to gather and analyze. The most important question I asked myself was if the resulting practice of research was fruitful in terms of research discovery. Some other questions I asked myself as interviewer and observer were:

1. Was I fully present?
2. Was I careful not to allow my desires, interests and needs distort the interview?
3. Was I aware of my esthetic sense?

4. Did I check my intuitions with the person by reflection?
5. Did I capture the person as well as the topic?

I felt that my answers to all the above questions were in the affirmative, as discussed below. The ability through research to uncover the relevance of using the 10 Servant-Leadership principles to provide congruent care to an ethno-cultural community was transformational to me.

I found the research experience meaningful and life-changing from my perspective as a nurse-midwife who desires to provide culturally congruent childbearing care to Amish women. It was rewarding to be able to understand the meaning Amish women have constructed in terms of their *ordnung* and the ethnographic event of childbearing in their lives, and the resulting implications for nurse midwives as Servant-Leaders. My concern for the Amish families empowered me to desire and plan research time that was meaningful and helpful for both of us. I was careful not to distort the interview, and verified the facts as I understood them with the participants. I felt the participant's voice and their heartfelt responses were captured in my journaling. Because of the subject matter of the study and its relevance to the provision of cultural caring by building trust and breaking down barriers that impede communication, it is believed the data could be transferable to other disciplines seeking to provide culturally congruent care.

The criteria I used for evaluating my qualitative research project were comprised of eight components of ongoing relevance checks for reliability and validity. The following are validation questions I asked myself again at the completion of this study.

First, is the study presented clearly, developed logically, and analyzed soundly, based on the data and methodology used? Yes. Utilizing the expertise of known research techniques as mentioned in my methodology section, employing the expert knowledge of my committee frequently, and obtaining ongoing member checks from the participants added validity and scholarship to my study. The sound logic and analysis provided implications for future practice. These implications included the fact that if a care provider who desires to give culturally congruent care to the Amish subscribes to Servant-Leadership guiding principles, the relevance and implications are life-changing for their clinical practice.

Second, did the literature review provide a historical perspective and support the findings of the data? Yes. After a thorough literature review including thorough examination of many research studies, books, and journal articles, having discussions with authorities on Amish studies, and receiving daily internet updates (ProQuest and Google) new dissertations and newsworthy Amish and Servant-Leadership happenings, I felt the ongoing literature review well-represented reality.

Third, was the project structurally sound? Yes. The mechanisms in place to check for accuracy and credibility, such as member-checking and receipt of committee and expert feedback along the way, were valuable for preserving the integrity of the data.

Fourth, was there sufficient depth of intellect? Yes. Again, having expert professionals checking the process all along the way, utilizing their skills as research experts, content specialists, and methodology practitioners was affirming.

Fifth, were any metaphors and images used in such a way as to communicate effectively? Yes. Working closely with my professional writing team offered valuable

feedback of what constitutes effective communication. Also, the positive comments made by the Amish women themselves regarding my metaphors and imagery were affirmative.

Sixth, will the project be useful and make a contribution to the health care community? Yes. I already have experienced positive feedback from other health care professionals, educators, and experts in the field on the helpful nature of this information for those who work with the Amish people.

Seventh, is the collection and presentation of the data meaningful in terms of the experiences of the informants, the researcher, and the committee? Yes. Again, I have received positive feedback on how interesting, helpful, promising and solid the scholarly process and the content matter have been.

Eighth, was there at least one alternative representation presented? Yes. There are three alternative representations of the data: case study presentation, found poetry, and metaphoric illustration. A model was used to describe the parallel between the Servant-Leader characteristics and the confluence of the themes and the research questions.

### Representations of Data

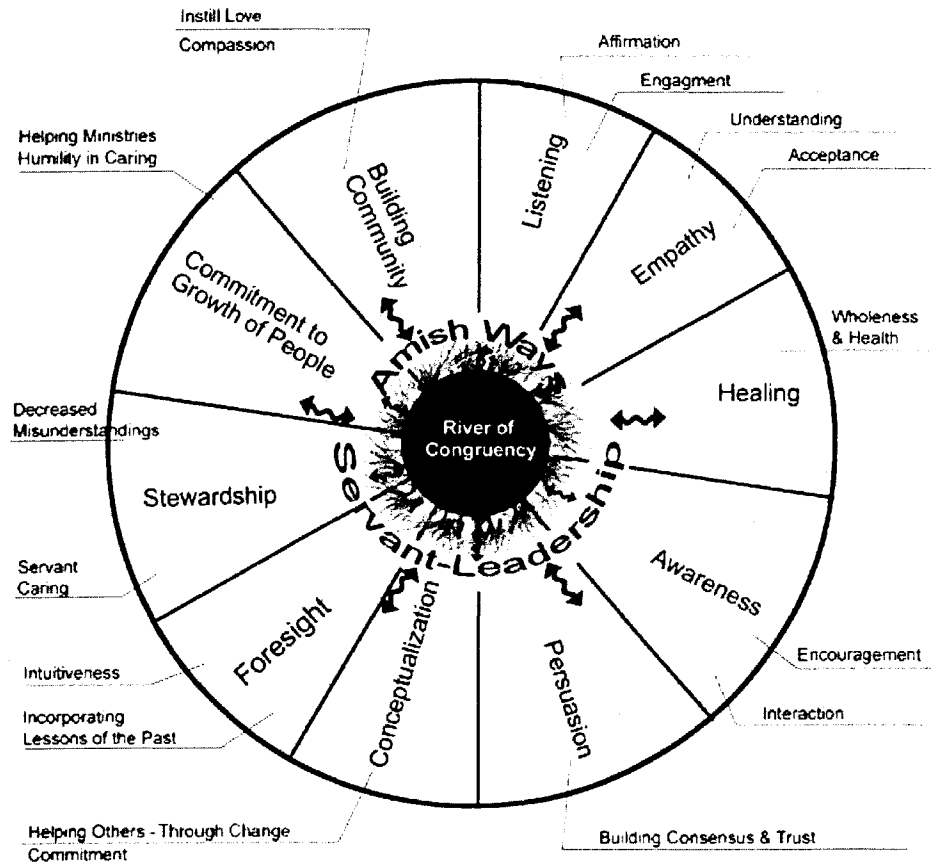
Employing a case study analysis to describe the emerging themes was a useful way to communicate the inquiry. This method facilitated my ability to communicate the findings and also helped me examine more completely the meaning of the Amish women's lived experiences. Using individual case studies allowed for in-depth examination of many aspects of the phenomenon of childbearing within the Amish culture, and the implications their health care beliefs hold for the nurse-midwife as a Servant-Leader care provider. The found poetry representation in the closing statement of chapter 4 allowed the reader to be drawn into the lives of the Amish women through their



eyes, in their voice, and from their perspective. The Streams metaphor application was used in the depicting of the visual Concept of Care model illustrated in this chapter (Figure 1). This visual model illustrates how the 10 guiding principles of the Servant-Leadership model (the streams) feed into the river of congruency of the Amish culture.

The Concept of Care visual model represents the coherence found between the three themes and the Servant-Leadership model. The first theme of understanding is that cultural beliefs are important and practiced by the Amish women. This is illustrated by the concepts listed outside the wheel. The second theme of understanding is that concepts of caring (the characteristics inside the wheel) are part of the culture of caring described by the Amish women themselves and need to be included in the practice of the caregiver if the plan of care is to be meaningful and followed. The third theme of understanding is that congruent principles (the 10 characteristics of Servant-Leadership listed) need to be used by the nurse-midwife or care provider for culturally sensitive care to the Amish childbearing women to occur.

The themes are depicted on the model which is a wheel of Servant-Leadership characteristics and Amish ways that make up the beliefs and practices of the Amish women in this study. These beliefs, practices and characteristics intersect and feed into a river of congruency, made up of concepts of caring that are both the attributes of Servant-Leadership and Amish care constructs. All three themes are represented on the model through the attributes on the rim of the wheel, based on the Amish women's comments and observations that were made in the field. The Servant-Leadership principles were found to be guiding principles that can be used as culturally congruent principles because of their alignment with the Amish *ordnung* and lifeways.



10 Guiding Principles (the streams)  
that feed the Concepts of the Caring Model (the river)

*Figure 1.* The 10 guiding principles of the Servant-Leadership model (the Streams) and how they feed into the Concept of Care model (the River of Congruency).

One small stream (each characteristic or attribute) at a time feeds a large river of congruency and culture caring. The concept that the mightiest of rivers is first fed by many small trickles of water has keen implications for me as a Servant-Leader to my patients, to my research participants, and now to my readers in relevance to Greenleaf's question. Robert Greenleaf's (1977) first written definition of a Servant-Leader was to be a servant first, knowing you have succeeded as such when those served grow as persons—that those who are served become healthier, wiser, freer, more autonomous and more likely themselves to become servants.

Greenleaf inspired me through his words that this concept of care also needs to be the hallmark of good research. I hope and trust and pray that all my informants and all my Amish friends felt served and will continue to be served and continue to be servants themselves. Spears and Lawrence (2002) described the excellence observed in the workplace and lives of practitioners using the Servant-Leadership model as an expanding river with deep currents. In this study, their prediction proved to be meaningful; the 10 characteristics of Servant-Leadership were the guiding principles that fed into the larger river of understanding and change. The participants in the study identified that if these 10 characteristics, congruent with Amish ways, were utilized by health care providers the likelihood of any proposed interventions suggested by the care provider would be greatly increased.

The culturally congruent principles described in this study have been identified by the Amish women themselves as capable of building trusting partnerships and having the potential to create an environment of trust so that education and culture caring interventions are more likely to occur without misunderstandings. The concepts of caring

are part of the Amish culture and are congruently a part of the Servant-Leadership culture, as exhibited in the above figure. The concepts of caring are both valued and practiced by the Amish women themselves and are also valued by the Amish women as a desirable characteristic for the nurse-midwife or health care provider to have.

## **Discussion of Findings**

### **Relevance of the Servant-Leadership Model**

The 10 guiding principles of Servant-Leadership make up the model of care to which I subscribe. I found this to be especially significant when concepts of caring are part of an ethno-culture; these concepts need to be incorporated into any health plan created by practitioners who desire to give culturally sensitive, congruent, and meaningful care.

The 10 characteristics of Servant-Leadership provided a solid conceptual foundation. Principles such as listening, showing empathy, demonstrating healing, awareness, gentle persuasion, conceptualization, foresight, stewardship, commitment to the growth of people, and desiring to build community with the participants in my study helped me to connect with them and exhibit sensitivity to the Amish way of life. This sensitivity in turn inspired trust on the part of the Amish women of my motives and actions.

I learned the pleasure of connecting with the Amish women by listening to their narrative without feeling the need to make a value judgment on what I was hearing. This was important for controlling bias during the course of this research. As a nurse practitioner, being able to apply the Servant-Leadership principles and knowing that they were congruent with the Amish ways will enable me to make a positive impact on the

childbearing health care of my Amish clients. As a result, meaningful interventions based on trust can be implemented to bring about risk reduction and promotion of successful health care choices together in a partnership.

The participants both valued and demonstrated the importance of the 10 guiding principles of Servant-Leadership throughout this study. First, listening was observed as a very important attribute for the nurse-midwife or care provider to have. This was most readily apparent in the way the Amish childbearing women would affirm how important it was for someone to listen to their questions and take note of their concerns. Most of the Amish women also listened intently and valued listening as a way to express concern and caring for another individual. The Amish women smiled often and nodded their heads to show they were listening and engaged with me during the visits. Often the children would join us at the table to listen to the discussions, but were very respectful and did not try to enter into the conversations. The mothers made a deliberate decision to teach their children the art of being a good listener by having them quietly join us at the table.

Spears and Lawrence (2002) acknowledged that listening is an important characteristic for a Servant-Leader. Listening encompasses getting in touch with one's own feelings and really seeking to understand with one's heart what is being communicated. I never experienced at any of the homes the phenomenon of more than one person trying to speak while another spoke. I witnessed even the babies cocking their heads and listening intently while the mother spoke, and then, in their infant babbling, sometimes offering a response. I felt the Amish have the art of listening down to a science. They set a high standard that all of us could learn from.

Second, empathy was recognized and observed in the ways the childbearing

women would empathize both with those around them and with me when stories were shared about childbearing concerns. The verbal and non-verbal expressions of acceptance and concern shown for others often were observed. The Amish women often would inquire about the children or relatives of other patients the physician gatekeeper visits. They would offer empathetic expressions of concern if the physician had been away and was not getting much rest and over the plight of the Amish women with having so few choices for childbearing. Many of them expressed their wish that there were other options such as birthing centers or nurse-midwives in the community. They all expressed empathetic concern over the lack of availability of affordable childbearing care. The Amish women strived to understand and focus on how, through my study, they could help others give sensitive and meaningful care to all Amish families. I found it refreshing that they had not only an interest, but also a heartfelt desire to try to help.

Spears and Lawrence (2002) addressed the need for a Servant-Leader care provider to recognize that people need to be accepted and recognized for their gifts and uniqueness. I found that the Amish women in my study seemed to appreciate very much that English care providers wanted to provide culturally sensitive health care. They especially appreciated the care provider who felt their job was a ministry or calling to help others. Even if my actions were not always acceptable, I always felt that I was. One of the participants wanted to share with me some of her crafts, and I in turn wanted to share my silk scarf. It was not a particularly colorful one, since I always tried to dress in subdued colors and be respectful of their dress code. I had hoped she would use it, as a dressing scarf on her table since I had noticed other Amish homes having what I thought

were similar accents. She kindly thanked me but told me it would be showing pride if she displayed it, but appreciated my kindness and affection.

Third, the characteristic of healing was emphasized by the childbearing women as a powerful force for transformation and integration of health and well-being. It was observed that if care providers were to be accepted, they must be respectful of the Amish women's desire to use natural means methods for health care and well-being. The culturally sensitive care provider would do well to incorporate as many natural remedies and herbs for childbearing needs as possible. The Amish women expressed appreciation and demonstrated compliance with any of the natural remedies suggestions made by the physician care provider. It was observed that the Amish women would write down on their wall calendars or notebooks any interventions suggested and on return visits would show the care provider the record and the results.

The search for wholeness and health was discussed as something the Amish share as a common goal. Their worldview/*ordnung* puts natural ways as God's ways in the center of their beliefs. This ideology affects their ideas of health care, and what is important to them to do to stay healthy. The Amish women expressed appreciation and allegiance to a health care provider who had a gift for understanding their ways and showed a desire to help them be healthy. All agreed that if a care provider were to incorporate as many of their natural ways as possible into the plan of care, they in turn would be willing to use interventions that may be more of what they deemed a medical model of care. They felt they could trust someone who tried to recognize how important it was to them that God's ways are, for the most part, natural ways and a large part of the healing principles they believe in and practice.

Spears and Lawrence (2002) affirmed that one of the great strengths of Servant-Leaders is their ability to recognize that many people have broken spirits and a variety of emotional hurts and therefore need healing. The caring and sensitivity shown by a Servant-Leader practitioner can be a powerful force for transforming these ills. I felt that as a Servant-Leader care provider I had an opportunity and privilege to help make my clients whole once I understood what healing acts were congruent with their beliefs and practices. I now was enabled with tools with which to serve.

Fourth, awareness was a characteristic observed in the communications between the physician gatekeeper and the participants. Their physician friend was acutely aware of the surroundings, the challenges, and the subtle differences in the environment or condition of the patient from one visit to the next. Interacting in the patients' homes affords the care provider unique opportunities not often afforded other care providers, who practice outside of the patient's environment. The physician friend gave articles of clothing, food, herbs, medicine, and literature very generously to help the Amish women to have additional assistance during childbearing. She carried patient educational materials and her lab right along with her. She continuously encouraged the Amish women to be acutely aware of any changes or risk assessment deviations between visits. The Amish women would write down on their calendars any deviations from the lists of things to be observant for that the care provider gave them.

Spears and Lawrence (2002) explained that, both generally and specifically, self-awareness is a characteristic of strength for Servant-Leader care providers. Making a commitment to foster awareness aids in understanding issues that involve the ethics and values of the one you are serving. In turn, the Amish women showed self-awareness and



strength as they took full responsibility for their care. They reasoned appropriately and with conviction as to why there were deliberate deviations from the agreed-upon plan of care.

Fifth, persuasion rather than the use of coercion or power often was observed in the ministry of the physician friend to the Amish childbearing women. She had a special way of helping build consensus around important childbearing interventions with the Amish women. If an important issue arose, she would rely on their partnership of trust to persuade rather than her positional authority as care provider when seeking to convince the Amish woman. Often she would cite examples of other Amish women in the community to make her point. Interestingly, most often the Amish women in turn would see the importance and would offer other examples that they remembered that reinforced what the care provider was saying.

Spears and Lawrence (2002) gave credence to the element of persuasion as another characteristic of Servant-Leaders that is effective and one of the clearest distinctions between traditional authoritarian models and that of Servant-Leadership. Many of the Amish women confided to me that they would not follow the directions given by a care provider who tried to coerce them into doing something they did not like or understand or that they felt went against their beliefs and practices. If the care provider was trusted and had shown willingness to listen and incorporate Amish holistic practices, then, and only then, would they agree to change.

Sixth, conceptualization was observed in the way both the physician care provider and the Amish women viewed the Amish culture and values as a positive force for society that needed to be encouraged. The physician friend would give credence to

childbearing practices that were helpful in maintaining a healthy pregnancy and delivery. She put these wholesome practices into operation by incorporating them in her care plan for the Amish ladies. The Amish women expressed appreciation for this action, and verbalized to me that it had helped them to trust her interventions to assist them. I asked if I, as a nurse-midwife, would conceptualize my practice to include the Amish health care practices based on their worldview into my practice with the Amish women in my community it would build trust and show caring. The Amish ladies affirmed my question and felt it would make a significant difference in building a trusting relationship.

Spears and Lawrence (2002) inspired Servant-Leaders to view every challenge from a conceptualizing perspective. This means to think beyond day-to-day realities and encompass broader, more visionary, goals of helping others on a long-term basis. This is what I observed and heard from the participants in my study. The Amish women dream big dreams of having inexpensive and safe childbearing care that is congruent, sensitive, and based on trusting and caring relationships with their health care providers.

Seventh, foresight was demonstrated in the observations I made of the Amish women in their recognition of the part that foresight has in incorporating the lessons of the past to create a positive presence for today for their children and family. The Amish women also seemed to intuitively understand the importance of foresight for the future preservation of the Amish values that are so important to the boundary protection of their culture. The physician gatekeeper also seemed to be appreciated by the Amish women because she as a health care provider understood the need to incorporate the lessons she had learned from many years of being a friend and care provider to the Amish, as well as how best to provide them with culture caring practices. She expressed affection, as well

as concern, for the lifestyle and the struggles of the Amish women and the consequences of their decisions for the future.

Spears and Lawrence (2002) recounted how foresight is deeply rooted within an intuitive mind, leading to the conjecture that it is, for Servant-Leaders, a characteristic most deserving of careful attention and conscious development. The Amish women also rely heavily on the lessons from the past, and how those lessons link to the realities of the present. More than once a participant mentioned that the lessons handed down from their ancestors had given them a bulwark of solid standards on which to raise their families in the Amish way.

Eighth, stewardship was a characteristic very readily valued by all the Amish women who participated in my study. They expressed that everyone has a responsibility for being a good steward, both to others and to the opportunities that God gives us to serve. Our work, our land, and our children all are blessings and it is our duty to take care of them and serve in the best way we can. They do this by working hard and sharing with others with a passion and zeal, believing that their gifts are a gift from God to be used for the service of others. Servant caring was viewed by the Amish women as a sure way to decrease misunderstandings. If a care provider's actions were viewed as servant-caring, then the best intent was naturally assumed.

One example that illustrates this principle of stewardship and servant caring is how the husband of one of the participants uses his gifts of massage to heal the sick in the Amish community. His service is deeply appreciated and misunderstandings are unlikely because his service is viewed as a service of ministry and a gift from God. The Amish women serve their community in a very quiet, unassuming manner and will often work

extra hours outside of their busy schedule to help anyone in need. These principles of service are part of stewardship to others and are taught early to the children; they are expected to help others in any way they can. Spears and Lawrence (2002) elucidated that holding one's gifts for the greater good of society is a first and foremost commitment to serving the needs of others in an open and honest way.

Ninth, commitment to the growth of others was observed as being central to the Amish ways. They are deeply committed to helping each other have healthy and happy families. The participants in the study verbalized their desire for themselves and their families and communities to be healthy, well informed, and able to care for themselves holistically. The Amish women also expressed many examples of encouraging others both physically and spiritually, and offering their help to members within their community. I heard directly from the Amish women the high value the Amish place on the observance of the virtues of humility and caring.

Spears and Lawrence (2002) spoke highly of the commitment to the growth of every individual as an important characteristic of being a Servant-Leader. Servant-Leaders believe that people have an intrinsic value and that there is a tremendous responsibility to nurture the personal, professional, and spiritual growth of each person we serve. Preserving family values that play a significant role in maintaining the growth of the Amish family and the ways of the *ordnung* are seen as an important commitment to the overall growth of people.

The Amish women believe and expressed to me that the Amish ways are the best ways to build a sense of belonging and live a redemptive life in harmony with what God

wants for us. If I am to have a positive influence in my Amish client's lives, I will value the commitment they have to each other within their communities of belief.

Tenth, building community, the last characteristic of the Servant-Leadership model, was evident in the way the Amish childbearing women instilled love and compassion in their practices of everyday living. The women in my study attempted throughout their everyday lives to strive for more healthy pregnancies and families by focusing on engaging themselves in meaningful labor and self-care, employing all the ways they knew to achieve this end. If a care provider is in a trusting health care partnership with them, they will be able to make suggestions for interventions that will help accomplish these goals.

I also need, as a nurse-midwife, to be committed to improving the status of pregnancy and childbearing and the quality of life for my Amish clients in any way I can. I need to be committed to the same principles of caring and show respect for their beliefs and practices as I partner in their childbearing care. I need to understand that true community building for my Amish friends means demonstrating self-sacrifice, submission, obedience, right living, and showing caring to God and to your fellow man.

Spears and Lawrence (2002) heralded the characteristic of community building as being an important part of culture caring. Servant-Leaders must be aware of the need to retrieve much of what has been lost in recent history as a result of not appreciating local culture and communities, not allowing them to become the primary shapers of human lives. The concept of community-building, among the Amish, is building relationships among those who work and live in that community in a way that is meaningful to them.

Spears and Lawrence (2002) advocated that the model of Servant-Leadership as a guiding dominant philosophy can offer great hope for the future by creating better, more caring practices. I was energized and challenged by my research to apply these guiding principles of Servant-Leadership theory to my practice as a care provider, and to offer suggestions for others; to put mechanisms in place that would help build trusting relationships with their Amish clients.

These guiding principles of Servant-Leadership form a model that is not only culturally sensitive and congruent with Amish ways, but is an intellectual and informed model that has transferability across disciplines. These concepts of caring are an integral part of most cultures, and it is permissible to deduce that any time we as researchers, educators, or communicators want to impact groups at the grass-roots level we need to find consensus with their worldview. It then becomes a meaningful way to build stronger relationships and partnerships. The many streams that make up of the 10 Servant-Leadership characteristics have the potential to form a great river of caring and ministry.

Utilizing the Servant-Leadership principles during data collection tended to inspire confidence in the study participants, and was a gentle reminder to me that preconceived ideas or judgments hamper good communication practices. This experience allowed me as the researcher to understand my own narrative; enabling me to truly listen to the Amish women's narratives while exploring and analyzing the data as it related to the conceptual underpinnings of the study. I enjoyed interviewing the Amish women as they discussed different topics related to their individual life narratives; I felt that my ability to see myself as the primary instrument for gathering and analyzing data for qualitative research was a humbling as well as an awesome responsibility.

One such example of the diversity of thinking among the women developed early in the study when all Amish women responded to the question of how they defined health by saying it was the ability to do their work. Some explained that doing their work was an important part of taking care of their families, particularly of their children. One of the most poignant responses came from an Amish mother who had lost seven children to CF and two of her eight remaining children had the disease. Both of these would also be lost unless a miracle occurred. She shared how at one time she took the concept of health for granted, but now her definition of health means having your child around for just one more day to love and hold. She voiced how important health was to her; every day of life holds possibilities and adds to our memories.

Another Amish woman I interviewed insisted that her understanding of health was to enjoy the world she lived in and not have so much pain. An English driver had hit her Amish buggy and she was partially paralyzed and unable to do many things she wanted to do for her family. She had always loved gardening, being an Amish midwife, and taking walks with her many grandchildren around their farm, which she is no longer able to do. A less than scrupulous investor stole the money she received for physical therapy, and she was no longer able even to receive the rehabilitation treatments she needed. The beauty in this diversity was revealed as each woman shared why their work was so deeply important to them.

My time in a Midwestern Amish community, working among the Amish families alongside their trusted female physician and friend who was the gatekeeper, affirmed my respect and concern for Amish childbearing women. This experience provided me an opportunity to conduct my study in an ideal and idyllic setting and to add to my store of

knowledge. That knowledge was built slowly, from my pilot study in another state, to my recently completed months of observation with an Amish care provider in another Amish community.

This knowledge endowed upon me an understanding of Amish ways. I became convinced of the importance to build a trusting relationship with the Amish women in my study. I incorporated five aspects of culturally congruent research principles to help build relationships. First, I as the researcher have an ethical responsibility to the participants; everything I do must be for their best interest. Second, any knowledge gained and all interventions developed must have value for those participants. Third, when the researcher and the study subjects have a partnership that is built on a trusting relationship, it becomes easier to share information and facilitate ideas that nurture both communication and honesty. Fourth, I needed to be aware that in order for the Amish women to share from their lived experiences, I as a researcher must be knowledgeable about their worldview. I could not otherwise explore openly their health care beliefs and practices. Incorporating the guiding principles of Servant-Leadership helped me as a researcher to uphold these tenets.

### Relevance of the Literature Review

In support of the literature reviewed, three basic assumptions, based on research literature from the five seminal studies summarized in Table 1, were affirmed in this study. First, the decision-making processes for Amish women are influenced by their ethno-historical, educational, social, and religious health care beliefs and practices concerning childbearing. Second, Amish childbearing women follow principles of the *ordnung* that are beneficial for sharing with care providers; sharing of the *ordnung* allows



care providers to better understand the Amish woman's childbearing beliefs and practices. Third, creating and applying a culturally congruent model of care creates fewer opportunities for misunderstanding, and builds mutual trust and respect between Amish women and their care providers (Miller, 1997; Nelson, 1999; Schwartz, 2002; Wenger, 1988; Yoder, 1984).

Yoder (1984) described Amish health-care-seeking behaviors and found certain characteristics that were preferred in nurse practitioners who partnered with them in their care. She suggested that Amish women preferred a nurse practitioner who demonstrated a caring attitude, and had good interpersonal and technical skills, as opposed to one well-versed in technical skills but lacking the ability to connect. This concept also was voiced in different ways by most of the women who participated in my study. These interpersonal skills were directly linked to the guiding principles identified in the explored Servant-Leadership questions.

The study by Schwartz (2002) on breast health and practices among Amish women discussed the importance of expanding the knowledge base of nurses and nurse researchers in the area of the Amish culture's health care beliefs and practices. The study provided tangible ways and means to provide culturally congruent care to this vulnerable population—one that is suspicious of the intentions and practices of persons outside their culture.

Schwartz (2002) encouraged care providers to treat Amish patients with respect and non-judgmental attitudes. This was especially important with regard to their religious, folk, and alternative health practices. Her research substantiated Amish women's feelings that they were more open and receptive to education and suggestions

for care if it was grounded in the principles they valued. All of the Amish women in this study on childbearing voiced such sentiments from their own perspectives: they affirmed that if a care provider understood the Amish ways and was sensitive to those ways in a childbearing care partnership, an Amish woman would be much more likely to go along with the plan and/or interventions suggested.

A study concerning Amish women's perceptions of communication with non-Amish caregivers in matters of health was reported by Nelson (1999). She interviewed three midwives and one Amish woman using open-ended questions. Nelson found that Amish women engage in health care via folk and alternative remedies during their pregnancy. Trust in the care provider, cost of treatment, proximity of the care provider to the woman's residence, and recommendations from others in her community all influence the Amish woman's decision about health care.

The Amish women in this study on childbearing repeatedly substantiated these values during our conversations. They expressed having a hard time providing for their families and finding it difficult to pay for health care. The Amish midwives who assisted them in childbearing understood this and offered their services for free or exchange of goods, and if the families could pay, then \$25.00 was accepted. Since the area was quite rural and entrepreneurial activities were not as common as in some of the other Amish communities, this flexibility was vital. However, even in Amish communities with more entrepreneurial opportunities, I witnessed the Amish belief that being good stewards means not spending a lot of money on health care so you were able help the less fortunate in your Amish community.

Amish women also believe that God's ways are more natural and should be the first line of defense when seeking health care. Proximity to health care is always a concern due to the religious practice of not owning automobiles. The cost of hiring a driver often is prohibitive, and other means are often sought to provide and maintain good health. These health care beliefs and practices acutely affect the variables of trust, cost, and proximity of health care.

Yoder (1984) substantiated in her research that the Amish prefer indigenous rather than modern health services and desire affective instead of technical characteristics in the nurse practitioner. Integrity, sympathy, empathy, listening with presence, and use of holistic healing were valued. Other characteristics such as awareness and exhibiting caring toward others were also considered important by the Amish.

Culture practices are at the core of the Amish worldview and social structure. These cultural practices are basic principles that guide choices in everyday life. My study strongly confirmed that cultural practices are part of the Amish worldview and social structure, and that having a model congruent with these basic principles helps build trust and decrease misunderstandings. In both her dissertation (Wenger, 1988) and a journal article (Wenger, 1995), Wenger supports the importance of understanding the concept of caring, both from the Amish woman's orientation to her culture and from her anticipation of what she expects from her care providers.

Four major themes were extracted from Wenger's data. First, culture care is at the core of the Amish culture. Second and third, the Amish actively participate in care actions and anticipate what the family and community needs are for well being. Fourth, care decisions are a matter of principle and guide the Amish's choices daily. The Amish

women in my study confirmed these principles as well. Applying these principles in health care planning for Amish families can provide a breakthrough in understanding how culture care concepts from the Amish woman's perspective directs her health care choices and decisions.

Miller (1997) reported specific health practices related to childbearing. The implications for advanced practice nurses from her study encouraged the advanced practice nurse to have knowledge and respect for the Amish culture if they are to be effective. Becoming a trusted care provider requires certain skills for the provision of congruent care. My study affirmed this finding, illustrating how using the 10 guiding principles of Servant-Leadership provides the means for incorporating skills that are not only congruent with Amish beliefs and practices, but also provide the tools to demonstrate respect and caring that are meaningful to their lifeways.

Both Hostetler (1993) and Kraybill (1998) advocate that the best way to understand the values and life-ways of the Amish is to understand the keen awareness of the place that religion and community culture have and hold in the life of the people. Religious and cultural indoctrination occurs throughout life in the Amish community, and decisions are made only after careful consideration of the good or harm that will come to the entire community of believers. Care providers need to understand that the emphasis on community caring may cause a woman to withhold or not share her personal health care concerns regarding childbearing. Perhaps she is concerned about the community or family suffering from added expenses, or fears unflattering comments about her beliefs or religion.

The data from my study validated that communication flows easier when a bond of trust and caring is established. One way that this occurred was through me sharing my own personal knowledge and respect for Amish ways. Applying the 10 guiding principles of Servant-Leadership placed me in a position of trust; elevating me as one who desired to facilitate discussion and understand the beliefs and practices concerning their health care choices. The Amish women shared that trust is critical; they needed to know that the health care provider during childbearing cared about them personally and wanted them to experience positive outcomes for childbearing health. The 10 characteristics were shown to be guiding principles that held both relevance and congruency with Amish beliefs, and practical opportunity for application of positive health care partnerships with the Amish women during childbearing.

### **Implications**

The themes that emerged from my data collection correlated well with the research questions and the Servant-Leadership framework. The three themes affirmed the three basic assumptions that were based on the five seminal studies and the literature review. Cultural practices were found to be very important, and readily influenced health care choices during childbearing. Concepts of caring are part of the Amish culture of caring, and need to be included in the plan of care if interventions are to be meaningful and adapted by the Amish childbearing woman. Congruent principles, those that are consistent with the Amish women's beliefs and practices, need to be used by the nurse-midwife or care provider for culturally sensitive care to the Amish childbearing woman to occur.

The congruent relationship that came out of the data analysis between the research questions and themes was interesting and insightful. As I jotted down observations and conversations during my time with the Amish women and their families, it became apparent to me that certain themes were emerging. I also validated what I had read in the literature about Amish life and the congruence with many of the characteristics of the 10 principles central to Servant-Leadership. I began to see validity in the application of a model of care that contained these 10 characteristics.

Beneficial results in terms of risk reduction and holistic health care for these women seemed plausible, since so many of the characteristics already are part of their culture. Their present life still is very much shaped by faith and redemptive community and ruled by the law of the *ordnung*. Caring and service toward others in the community is very much valued and practiced. The 10 characteristics—listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, and commitment to the growth of people and the building of community—are in many ways a part of Amish life.

The concepts of right living are embedded in principles such as listening to others, and showing empathy and understanding as you seek to do the will of God, and embracing a simple lifestyle that includes natural means first as the first-choice method for prevention or healing. Showing awareness and acceptance of the code of standards that demonstrate caring and concern for others through acts of humility is also an important principle of the Amish lifestyle.

There are many social bonds in the Amish culture in addition to a personal commitment to the faith. Commitment is about self-sacrifice, submission, obedience, right living, and showing caring to God and to your fellow man. The Amish believe in

demonstrating a spirit of consensus and support as one gently persuades others to live in harmony and support community values. Another important principle is employing the attributes of foresight and faith to see beyond today's immediate needs and determine how they will impact the future of the community. This ability to understand the lessons from the past and make decisions for the present and future based on foresight are thought to bring harmony and eternal life.

The acts of stewardship and commitment to others are deeply rooted in the holistic lifestyle of the Amish. Community is built by supporting and incorporating the tried ways of the past into the present and adding hope for the future by a life of obedience, humility, and caring. I felt privileged to have had the opportunity to participate in Amish life; to embrace their joy of birth and love of family and community. Most of all, I celebrated their admiration for creation and the Creator, their respect for others, their ability to live a life of order, and their practice of personal rather than impersonal relationships in a world where community and human contact are not always so valued.

One Amish woman shared with me that it is difficult not knowing until you die that you can have the assurance of salvation. You must wait until the judgment to know if your life was worthy. She expressed a great desire to feel at peace about knowing that Jesus as her personal Savior could and would cover her unworthiness, even now. It was satisfying to share information that could guide her towards that understanding. This research enables those who desire to give culturally congruent care to childbearing Amish women to explore the use of guiding principles that provide a tangible way to reach this

vulnerable population suspicious of the intentions and practices of persons outside their culture.

Utilizing the 10 guiding principles of Servant-Leadership in this study was shown to have significance; they created an environment that decreased misunderstandings and built a partnership of trust, thus enabling the care provider to implement culturally congruent and positive pregnancy interventions. The experience has been educational and life- changing. My mind has been transformed by the research process. The most rewarding experience for me was the heart-sharing and relationship-building with the participants. I have appreciated the openness of the participants in sharing their life narratives with me. The grace of great things is the humility I felt when I truly experienced another's soul, because they felt free and safe to share, and together we felt love enough to embrace this great gift.

This journey has required no less from me than to learn tolerance for ambiguity, to be sensitive and caring as a Servant-Leader researcher, to be compassionate with my listening, and to demonstrate competency in my communication practices. I found that utilizing the 10 guiding principles of Servant-Leadership in my research approach helped me to focus on being open and adaptable to my participants' worldview and life stories.

Servant-Leader principles, when employed honestly, will assist the care provider who is seeking to serve others build a sense of community, sensitivity, and trust.

I felt fortunate to be involved as researcher in a study with a people-group for whom I have such a personal commitment and respect for. I care deeply for these strong, committed families whose stories and characters have enriched my life and are the essence of this study. These women continue to teach me so much about the joy and



beauty of birth and of life, and the power and healing that relationships bring with family, friends, and community. My desire is to give back in a way that has significance for them as their care provider and friend.

### **Recommendations for Future Research and Practice**

The strength of this study is in the richness of the findings, based on the Amish women's own perceptions about how ethno-cultural beliefs influence health care during childbearing. Concepts of caring are part of their culture and were found to be important enough that they need to be included in the plan of care if it is to be meaningful. Utilizing a Servant-Leadership model of care that incorporates these guiding principles will assist care providers in their role as educators to implement interventions that are culturally sensitive and more likely to be adopted by the Amish childbearing woman.

This new knowledge about the congruency between Amish concepts of caring (part of the *ordnung*) and the concepts of caring identified within the Servant-Leadership model is of benefit to the nursing and health care communities that serve the Amish population. Utilizing the conceptual model of Servant-Leadership as a lens through which to explore Amish childbearing beliefs and practices facilitated the understanding of the health care reasoning and choices of the Amish women from an emic perspective. The use of a Servant-Leadership model has added value to the potential for transfer across other cultures and disciplines when the intent is to improve the status of health and the quality of life for women.

For example, I am especially excited about applying the Servant-Leadership concept of care model as I visit with and continue to assess the cultural beliefs and practices of the natives of Papua, New Guinea. Many of the concepts of caring of the

Servant-Leadership model also hold value in this culture. My transcultural nursing volunteer work enables me to connect with the women of the villages and to take a beginning step toward developing culturally appropriate patterns of caring for them and their children. The guiding principles of Servant-Leadership will help me to evaluate behavior, beliefs, and practices within the context of the individual and her or his cultural background and experience.

In summary, the guiding principles of Servant-Leadership are culturally sensitive, holistic and meaningful to Amish childbearing women. This insight will contribute to a decrease in misunderstandings and therefore better enable a care provider to implement culturally sensitive and positive pregnancy outcomes to a vulnerable population suspicious of the intentions and practices of persons outside their culture. Future researchers may contrast and compare findings from this study with results of other ethno-cultures to assess the transferability of the findings, particularly among cultures where a vulnerable population is at risk for misunderstanding due to isolation or their community's health care practices and beliefs.

In conclusion, there are eight essential insights addressed in this study that I will continue to ponder, and invite my readers to ponder as well in terms of future application for practice and or research.

1. The guiding principles of Servant-Leadership are congruent with the Amish ways (their *ordnung* has similar care concepts), as stated from the women's own perspective in the data, and have a potential to be generalized to other ethno-cultural groups.

2. If education is to be effective, cultural sensitivity is required. Using these congruent principles of Servant-Leadership will afford the opportunity for practitioners to go into the Amish culture and share ideas and suggestions that could impact their health care positively.

3. When these congruent principles of Servant-Leadership are adhered to, misunderstandings decrease and trust is established. This makes it possible to implement interventions that are accepted and respected by the Amish women.

4. As a result of applying the Servant-Leadership principles, it was shown that the Amish women were more likely to share more openly, to feel freer to question and explore options that would be meaningful to them.

5. When employing the 10 guiding principles of Servant-Leadership to share new knowledge, incorporate as many of the cultures' own health care beliefs and practices as possible, such as complementary herbs and natural remedy methods to treat symptoms.

6. Explore ways to make the Servant-Leadership principles work for your particular cultural setting and practice. Visiting in the homes, clinics, birth centers, hospitals, organizations, and community settings of potential participants will open up even more opportunities to share and discuss your vision.

7. Since traditional medicine is not always respected or accepted readily in the Amish culture, using these guiding principles of Servant-Leadership opened the doors for communication. The advantages in having a partnership that is built on mutual trust and respect were many. Schwartz (1995) promotes the idea that once research was completed there needs to be a venue to leave the informants with resources to integrate the new

insights that were discovered. This could be a health-related article or handout that had information that would be culturally meaningful and helpful on certain diseases, preventive measures or practices pathways that are beneficial for knowledge.

8. Use of the Servant-Leadership model has great value and promise for practice. The 10 guiding principles supply the user an action plan that proposes caring, sensitivity, and intelligent and informed concepts. These 10 guiding principles help solidify a congruent partnership between two different cultures; a partnership where each person is encouraged to listen and apply the other nine principles as well in situations where changes are necessary to incorporate culture-caring interventions.

The purpose of this ethnographic study was to explore the childbearing beliefs and practices of Amish women and how nurse-midwives as servant leaders may gain insight for teaching and promotion of health care to another culture. This study focused on understanding the Amish women's childbearing beliefs and practices from their perspective and using the data as a resource for health care teaching. The essence of the health care beliefs and practices of the Amish women related to childbearing was discovered through interviewing and observing Amish women. This allowed me to uncover the Amish women's meaning of their lived experiences in childbearing as it applied to their health care beliefs and practices.

According to research literature, Amish women are believed to be at high risk for problems during the childbearing period (Fuchs et al., 1990; Miller, 1997). Further, Amish women at risk may not be afforded opportunities to learn about risk reduction within the educational, social, and ethno-religious framework of their culture (Kraybill, 1998; Schwartz, 2002). Due to the Amish separateness from society at large, it was

unknown how using a Servant-Leadership model to provide care in a culturally congruent manner might decrease misunderstandings and build mutual trust and respect. This research granted an understanding of the childbearing beliefs and practices of the Amish women, thus allowing for better comprehension of their health care reasoning and choices.

These data can be used as a lens through which to explore possibilities for how a nurse midwife as a Servant-Leader care provider can facilitate education and the reasoning processes in Amish childbearing women. As a result of the data received, implications for risk reduction in the health care of Amish women in childbirth are possible through a partnership with Servant-Leader nurse midwives providing culturally congruent care. When the characteristics of Servant-Leadership are transformed into guiding principles by the care providers thinking and actions then these principles can be used as a tested cornerstone on which to build a solid foundation for a culturally congruent partnership.

**APPENDIX A**  
**LETTERS**

February 16th, 2004

Dear Friend,

I am a nurse-midwife and I like to partner with my patients in health care to improve the way I do my work and share with other nurse midwives ways that may help to give more sensitive childbearing care to our Old Order Amish families.

I will be conducting a study over the next year to hopefully gain information that will be helpful to all of us.

Would you please be willing to share with me your thoughts and suggestions on what you have appreciated about the care providers you have used during childbearing? I would appreciate any suggestions you may have to help others and myself to create a healthy and meaningful childbearing experience for the Amish women we serve.

Your help will enable me to educate other health care givers in issues related to childbearing in the Amish community in a way that is acceptable to Amish women.

Any information that you share will be kept confidential to the point that your name will not appear on any published document ever. The information that you share will not be shared with another person with your name attached.

I do feel this information will prove to be helpful in serving our Amish women and families and the care providers who want to provide good care. If you agree to talk with me, your friend Dr. McNeilus will set up a time that will work for both of us. We can meet at your home or at your choice of location.

My time spent with Old Order Amish women during their childbearing experiences has been and continues to be very special and meaningful to me. I am very respectful and appreciative of the beliefs and practices of Amish women and can assure you that the questions I would ask you would uphold in the strictest sense your Amish ways and values.

Sincerely,

Victoria L. Wickwire R.N.

**ANDREWS UNIVERSITY**  
**School of Education**  
**Leadership Program**

**Informed Consent Document**

**Title:** Amish Childbearing beliefs and practices and the implications for nurse-midwives as Servant-leaders

**Principle Investigator:** Victoria L. Wickwire, CNM, MSN, RN

**1. Introduction and Purpose (I have been told that)**

I am being asked if I would like to participate in a research study related to health care (beliefs) and practices of Amish childbearing women. I will also be asked to give suggestions for ways that care givers who want to be sensitive to those beliefs and practices can implement them. The researcher is a nurse-midwife and likes to partner with her patients to improve their childbearing experiences. The researcher wants to improve the way she does her work and possibly help other care providers of childbearing women as well. The purpose of this study is to explore the health care beliefs and practices of Amish women related to childbearing and how nurse-midwives as servant care givers may gain insight for teaching and promotion of care.

**2. Procedure (I have been told that)**

I am invited to take part in the study and will be asked to share what I know about Amish childbearing beliefs and practices and how care providers, such as midwives, can make the experience more meaningful for me. The researcher is interested in learning about my beliefs and practices during childbearing. My participation could include 1 to 2 sessions about an hour to an hour and a half in length. A tape recorder will not be used to capture my discussion, unless I desire it. Notes will be taken during the interview. The interviews will take place in a neutral location such as your home or Dr. Mary Ann McNeilus's home.

**3. Risks (I have been told that)**

There are no known legal or health risks related to this interview process.

**4. Benefits (I have been told that)**

The possible benefit to me for taking part in this study is that I will have an opportunity to share my thoughts and experiences with the researcher. In turn, this will enable her to educate others on issues related to Amish childbearing beliefs and practices in a way that is acceptable to Amish childbearing women. The researcher would like to learn from me what I believe and practice that aids in healthy childbearing experiences or prevention of misunderstandings and ways to build trust between care providers and their patients.



**5. Participant's voluntary participation (I have been told that)**

My participation in the study is voluntary. I may withdraw at any time without fear of intimidation or reprisal.

**6. Confidentiality ( I have been told that)**

All information I share in this study will be kept confidential in the sense that my name will never appear on any written document or revealed in a published source. The information I share will not be shared with another person with my name attached. My identity will be kept confidential in any publications.

**7. Costs (I have been told that)**

There are no monetary cost for me to participate in this study.

**8. Compensation** (I have been told that)

There are no monetary compensations or rewards for me participating in this study.

## 9. Contact Information

This study has been explained to me in detail. All my questions at this point have been answered. If I should have further questions, I may contact the researcher at 269-471-9417. If I have questions or concerns I would like to ask the researcher's advisor, I may contact Dr. Loretta Johns, (researchers advisor) at 269-471-3475.

## 10. Informed consent

I have read the contents of this consent form and have listened to the verbal explanation given by the investigator. My questions have been answered to my satisfaction. I hereby give voluntary consent to participate in this study. If I have additional questions or concerns, I may contact Victoria L. Wickwire at 9488 Park Ridge Trail, Berrien Center, MI, 49102. (269-471-9417)

**I have been given a copy of this consent form.**

Signature of Subject      Date

**Witness**

Date \_\_\_\_\_

"I have reviewed the contents of this form with the person signing above. I have explained potential risks and benefits of the study".

Signature of Investigator

Telephone #

Date \_\_\_\_\_

**APPENDIX B**  
**RESEARCH AND INTERVIEW QUESTIONS**

## **QUESTIONS TO GUIDE INTERVIEW WITH PARTICIPANTS**

I am a nurse-midwife and like to partner with my patients in health care to improve childbearing experiences. I am looking to improve the way that I do my work and also share the information with other care providers who work with Amish communities.

Please share with me your thoughts on the following questions:

**(relates to research question #1)**

How do the ethno-religious beliefs of Amish women influence their health care in childbearing?

1. Let's talk about childbearing practices in your community: okay?
2. For instance, what did you do when you thought you might be pregnant for the first time?
3. In your own words how do you define health?
4. How do you define a healthy childbearing time?
5. Describe to me the type of care provider you had with each pregnancy?
6. How do you see your beliefs influencing your childbearing experience?

**(next section relates to research question #2)**

Is there congruence between the Servant-Leadership model and Amish childbearing women's ethno-cultural beliefs?

7. In your opinion what can we do as care providers to be more sensitive to your childbearing needs?
8. What information would you want your care provider to know to best serve you in your childbearing?

9. What do you wish you had known?
10. What is most important to you concerning healthy childbearing?
11. Based on your experience with pregnancy and childbirth, what have you liked most about the doctor or midwives you have gone to?
12. What suggestions by the doctor or midwife did you find most useful?
13. What suggestions by the doctor or midwife did you find least useful?
14. Were there incidents since you began having children where you were concerned about the health of the child you were carrying?
15. How would you deal with any suggestions they gave you if you did not like the suggestions?
16. How would you share with them that you did not like their suggestions?
17. As a rule, do you think Amish women are more likely to see a doctor or a midwife for childbearing care?
18. Why do you think that is true or not true?
19. Do you think your practices are different in any way than Non Amish during childbearing?
20. Why or why not?

**(relates to research question #3)**

What are the culturally congruent guiding principles of Servant Leadership that assist the nurse midwives in their role as educators and promoters of health care to Amish childbearing women?

Researcher will use the 10 characteristics of Servant –leadership to give direction to questions (listening, empathy, healing, awareness, persuasion, foresight, stewardship, and commitment to the growth of people building community).

21. How do you know when your care provider is really listening to you?
22. How does it make you feel when you know you are being listened to?
23. Give an example of a time when a care-giver strived to understand your beliefs on childbearing? (empathy)

24. How could a care provider as a partner in your childbearing show concern about your preferences for healing?
25. How do you want care providers to show awareness for your childbearing practices? (awareness)
26. How do you prefer to receive information from your care provider about the importance of taking care of you and your baby during childbearing? (persuasion)
27. How does it make you feel if they try to coerce you into complying with their wishes?
28. How could your care provider show sensitivity to your Amish ways in planning childbearing care? (conceptualization)
29. Tell me how it makes you feel if your care provider has taken the time to try and understand your beliefs and practices from a historical view and freely incorporates lessons from the past? (foresight)
30. What do you think about care providers who see their roles as a ministry? (Stewardship)
31. How do you view care providers who take a personal interest in your care and your life?
32. How can they best do this in your opinion? (commitment to the growth of people)
33. Would you like to see your care provider involved in the Amish community in ways that build community?
34. What suggestions would you have for them to do this?

## DEMOGRAPHICS

Age:            Marital Status: M S W

Educational grade level:    ☐ Parochial school ☐ Public School

Health curriculum taught at school: yes or no

Siblings: Male ☐ Female ☐

Age at menarche: ☐      Age at marriage: ☐

Age at first pregnancy: ☐      Number of pregnancies ☐

Number of live births: ☐ Miscarriages: ☐ Stillborn: ☐

Birth weights of children: ☐

Complications of any pregnancies including this one:

---

Where have your children been born? Home, birth center, hospital?

---

Ages of children: ☐ Female ☐ Male ☐

Age at menopause ☐

Do you use herbs or homeopathic /natural remedies on a regular basis?

---

Major illnesses or limitations in family: For example: (I read a list of health problems that the participant can respond to) Yes ☐ or No ☐

You or your husband?

Parents

Aunts

Uncles

Grandparents

Siblings

Children

Do you or have you ever worked outside the home? Where?

Do you read non-Amish newspapers or magazines or listen to radio or watch TV?

Which ones and generally how often?

## **APPENDIX C**

### **FIELD NOTES TABLE WITH INTERVIEW SUMMARY FROM PILOT STUDY**

Table 4

*Field Notes With Interview Summary From Pilot Study*

Characteristics of Servant-Leadership	Spears' Definition	Correlating Observations From Amish Women's Responses
<b>A Servant-Leader will:</b>		
Listening	<ul style="list-style-type: none"> <li>• have a deep commitment to listening intently to others</li> <li>• consciously identify and clarify the will of others</li> <li>• Receptively listen with periods of reflection and recapping</li> <li>• Stay in touch with one's own inner voice</li> </ul>	<ul style="list-style-type: none"> <li>• Many of the Amish women affirmed how nice it was to have someone really listen to their questions and show interest and time for their concerns</li> <li>• The Amish women also listened intently and took notes as the NM responded to the questions</li> <li>• Often the young children joined us at the table to listen to the discussions. The Amish mothers taught their children at a very young age the value of listening. The youngest children sat quietly at the table and were very respectful of what their mothers asked them to do.</li> </ul>
Empathy	<ul style="list-style-type: none"> <li>• Value the ability to understand and empathize with others from their perspective</li> <li>• Accept others and appreciate their uniqueness even if they cannot accept certain performances</li> <li>• Demonstrate empathetic caring</li> </ul>	<ul style="list-style-type: none"> <li>• The verbal and non-verbal expressions of sympathy and concern as well as acceptance was often observed of the Amish women towards the NM, the researcher, neighbors, family and animals</li> <li>• Hot tea and food were offered if the Amish women felt we were hungry or cold</li> <li>• The children were taught empathy towards others and were given animals to care for to develop these traits at a tender age</li> </ul>
Healing	<ul style="list-style-type: none"> <li>• Value the healing of relationships and respect for another's health choices as a powerful force for transforming and making meaningful choices</li> <li>• Be sensitive to those with hurting spirits and those suffering from emotional hurts</li> <li>• Vision an opportunity to help make whole those they come in contact with</li> <li>• Understand the importance of forming a partnership with the one being served</li> </ul>	<ul style="list-style-type: none"> <li>• The Amish women verbalized how pleased they were when care providers were respectful of their practices and desires to use homeopathic methods for childbearing, they in turn were very open to suggestions by the NM for other interventions she may want them to try</li> <li>• The Amish women expressed how important the suggestions of the NM were to them and showed them the calendars or notebooks of how the interventions were going that the NM had suggested from prior visits</li> <li>• Partnerships between the NM and the Amish women were evident, mutual respect and caring was readily observed</li> </ul>



Table 4—*Continued.*

Characteristics of Servant- Leadership	Spears' Definition	Correlating Observations From Amish Women's Responses
A Servant-Leader will:		
Awareness	<ul style="list-style-type: none"> <li>Seize the opportunity that general awareness and awareness of ones own feelings opens up many channels for more integrated care</li> </ul>	<ul style="list-style-type: none"> <li>The positive interactions that occurred between the NM and the Amish women were directly related to the interest and awareness that both took in regard to each others needs</li> <li>Often the Amish women would ask the NM-how did you know that? The smiles and affirmation shown to the NM reinforced her beliefs that demonstrating awareness of others cultural practices and being in touch with how you feel goes far in strengthening a relationship built on respect and trust for each other</li> </ul>
Persuasion	<ul style="list-style-type: none"> <li>Seek ways to use persuasion rather than coercion to motivate</li> </ul>	<ul style="list-style-type: none"> <li>The special way the NM build consensus around important childbearing interventions was well received by the Amish women</li> <li>The Amish women often employed persuasion techniques with their children instead of coercion</li> </ul>
Conceptualization	<ul style="list-style-type: none"> <li>Provide visionary guidance as a positive force for change</li> </ul>	<ul style="list-style-type: none"> <li>The Amish women expressed pleasure whenever the NM would conceptualize her midwifery practice to include many of the Amish health care practices</li> <li>It was also observed that the Amish women would actively seek to implement any guidance the NM suggested</li> </ul>
Foresight	<ul style="list-style-type: none"> <li>Learn lessons from the past and other mentors and be willing to share them with sensitivity to those you serve</li> </ul>	<ul style="list-style-type: none"> <li>Affection and caring was openly shown for the NM by the Amish women, they often expressed the positive comments from many members of their community for her service</li> <li>The NM shared openly with the researcher how she had learned from her mistakes and patiently from her clients on what was important to them</li> </ul>
Stewardship	<ul style="list-style-type: none"> <li>Hold in deep trust the commitment to serving the needs of others in an open and generous way</li> </ul>	<ul style="list-style-type: none"> <li>The Amish women sensed that the NM served the Amish community with passion and caring-often comments were made that she should get more rest and get extra help</li> <li>These same characteristics were also seen in the Amish women towards others they came in contact with</li> <li>The principles of service were voiced as a gift from God to bless others</li> </ul>

Table 4—*Continued.*

Characteristics of Servant- Leadership	Spears' Definition	Correlating Observations from Amish Women's Responses
<b>A Servant-leader will:</b>		
Commitment to the growth of people	<ul style="list-style-type: none"> <li>• See each individual as having intrinsic value and worth</li> <li>• Recognize the tremendous responsibility to do everything possible to nurture the growth of people</li> </ul>	<ul style="list-style-type: none"> <li>• The Amish women openly expressed how each person is a gift from God and meant to be a blessing to humanity</li> <li>• Amish childbearing women took the responsibility very seriously to take care of their growing unborn babies and other children as well</li> <li>• The value Amish women placed on human life was often seen in the tender demonstrations of caring towards their neighbors and families</li> </ul>
Building community	<ul style="list-style-type: none"> <li>• Seek ways that true community can be created</li> <li>• Demonstrate caring for specific community related groups</li> </ul>	<ul style="list-style-type: none"> <li>• The Amish women expressed appreciation for the NM's commitment to the Amish community even at her own sleep deprivation</li> <li>• The concept of building community is a hallmark of Amish society and was witnessed often in their acts of caring and protection toward the community at large</li> </ul>

*Note.* NM = Nurse Midwife

## REFERENCE LIST

## REFERENCE LIST

- American College of Nurse-Midwives. (2003). *ACNM membership directory*. Unpublished manuscript, Washington, DC.
- Andrews, M., & Boyle, J. (2002). *Transcultural concepts in nursing care* (4<sup>th</sup> ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Armstrong, P., & Feldman, S. (1986). *A midwife's story*. New York, NY: Arbor House.
- Beachy, A., Hershberger, E., Davidhizar, R., & Giger, J. N. (1997). Cultural implications for nursing care of the Amish. *Journal of Cultural Diversity*, 4(4), 118-128.
- Bennis, W. G. (1994). *On becoming a leader*. Cambridge, MA: Perseus Publishing.
- Blair, R., & Hurst, C. (1997). Amish health care. *Journal of Multicultural Nursing & Health*, 3(2), 38-43.
- Blanchard, K., & O'Connor, M. (1997). *Managing by values*. San Francisco, CA: Berrett-Koehler.
- Bohay, I. (1989). *Ethnonursing: A study of pregnancy and childbirth in the Ukrainian culture within Leininger's culture care theory*. Unpublished master's thesis, Wayne State University, Detroit, MI.
- Brende, E. (1996). Technology Amish style. *Technology Review*, 99(2), 26-28.
- Brink, P. J. (1999). Transcultural versus cross-cultural. *Journal of Transcultural Nursing*, 10(1), 7.
- Buccalo, S. (1997). Window on another world: An "English" nurse looks at the Amish culture and their health care beliefs. *The Journal of Multicultural Nursing & Health*, 3(2), 53-58.
- Burchum, J.L.R. (2002). Cultural competence: An evolutionary perspective. *Nursing Forum*, 37(14), 5-15.
- Campanella, K., Korbin, J. E., & Acheson, L. (1993). Pregnancy and childbirth among the Amish. *Social Science and Medicine*, 36(3), 333-342.

- Campinha-Bacote, J. (2003). *The process of cultural competence in the delivery of health-care services: A culturally competent model of care* (4th ed.). Cincinnati, OH: Transcultural C.A.R.E. Associates.
- Chambers, E. (2000). Applied ethnography. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 851-869). London, England: Sage.
- Covey, S. (2001). *Leadership is a choice*. New York, NY: Simon & Schuster.
- Creswell, J. W. (2003). *Research design, qualitative, quantitative, and mixed methods approaches* (2nd ed.). Thousand Oaks, CA: Sage.
- Cronk, S. L. (1989). The redemptive process in Old Order communities. In J. A. Hostetler (Ed.), *Amish roots: A treasury of history, wisdom, and lore* (pp. 81-81). Baltimore, MD: Johns Hopkins University Press.
- Dahl, S. (2004). *Intercultural research: The current state of knowledge* (Middlesex University Discussion Paper No. 26). Abstract retrieved November 20, 2005, from <http://ssrn.com/abstract=658202>.
- Dellasega, C., Hupcey, J. E., & Fisher, K. (1999). Culturalizing health care for a culturally diverse population: The Amish. *Clinical Excellence for Nurse Practitioners*, 3(1), 10-15.
- Denzin, N. K., & Lincoln, Y. S. (Eds.). (2000). *Handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.
- DePree, M. (1997). *Leading without power*. San Francisco, CA: Jossey-Bass.
- Dobson, S. M. (1991). *Transcultural nursing*. London, England: Scutari Press.
- Eliason, M.J. (1993). Ethics and Transcultural Nursing Care, *Nursing Outlook*, 41(5), 225-228.
- Finn, J. (1995). Leininger's model for discoveries at the farm and midwifery services to the Amish. *Journal of Transcultural Nursing*, 7(1), 28-35.
- Fisher, S. E., & Stahl, R. K. (1997). *The Amish school*. Intercourse, PA: Good Books.
- Franker, A. T., & Spears, L. C. (Eds.). (1996). *The private writings of Robert K. Greenleaf: Seeker and servant, reflections on religious leadership*. San Francisco, CA: Jossey-Bass.
- Frick, D. M. (2004). *Robert K. Greenleaf: A life of servant leadership*. San Francisco, CA: Berrett-Koehler.

- Fuchs, J.A., Levinson, R. M., Stoddard, R. R., Mullet, M. E., & Jones, D. H. (1990). Health risk factors among the Amish: Results of a survey. *Health Education Quarterly*, 17(2), 197-211.
- Giger, J. N., & Davidhizar, R. E. (2004). *Transcultural nursing: Assessment and intervention* (4th ed.). St. Louis, MO: C.V. Mosby.
- Greenleaf, R. K. (1977). *Servant-leadership: A journey into the nature of legitimate power and greatness*. Mahwah, NJ: Paulist Press.
- Hall, E. T. (1959). *The silent language*. New York, NY: Anchor Books, Doubleday.
- Hall, E. T. (1976). *Beyond culture*. New York, NY: Anchor Books, Doubleday.
- Hall, E. T. (1984). *The dance of life: The other dimension of time*. Garden City, NY: Anchor Books, Doubleday.
- Hall, B. P., & Tonna, B. (1998). *Hall-Tonna inventory of values*. Santa Cruz, CA: Values Technology.
- Hesse, H. (1956). *The Journey to the East*. (Trans. Hilda Rosner). New York, NY: Noonday Press.
- Hewner, S. J. (1993). Eldercare in an Amish and an English rural community: A comparative medical anthropological study. *Dissertation Abstracts International*, 54(1), 08A, p. 3087. (University Microfilms No. AAG930076)
- Hofstede, G. (1991). *Cultures and organizations: Intercultural cooperation and its importance for survival, software of the mind*. New York, NY: McGraw-Hill.
- Hostetler, J. A. (1993). *Amish society* (4th ed.). Baltimore, MD: Johns Hopkins University Press.
- Hostetler, J. A. (1999). *Amish roots: A treasury of history, wisdom, and lore*. Baltimore, MD: Johns Hopkins University Press.
- Hunter, J. C. (1998). *The servant: A simple story about the true essence of leadership*. Boston, MA: Prima Publishing.
- Huntington, G. E. (1976). The Amish family. In C. H. Mindel & R. W. Habenstein (Eds.), *Ethnic families in America: Patterns and variations* (pp. 295-322). New York, NY: Elsevier.
- Huntt, D. C. (2001). *Living with physical disability in the Amish community*. Unpublished doctoral dissertation, Ohio State University, Columbus.

- Igou, B. (Ed.). (1999). *The Amish in their own words: Amish writings from 25 years of Family Life magazine*. Scottdale, PA: Herald Press.
- Kottak, C. P. (2006). *Anthropology: The exploration of human diversity* (11th ed.). New York, NY: McGraw-Hill.
- Kouzes, J.M., & Posner, B.Z. (1990). *Leadership practices inventory (LPI)*. San Francisco, CA: Jossey-Bass/Pfeiffer.
- Kraybill, D. (1989). *The riddle of the Amish life*. Baltimore, MD: Johns Hopkins University Press.
- Kraybill, D. (1993). Negotiating with Caesar. In D. Kraybill (Ed.), *The Amish and the State* (pp. 3-22). Baltimore, MD: Johns Hopkins University Press.
- Kraybill, D. (1998). *The puzzles of Amish life*. Intercourse, PA: Good Books.
- Kraybill, D., & Bowman, C. F. (2001). *On the backroad to heaven: Older order Hutterites, Mennonites, Amish, and Brethren*. Baltimore, MD: Johns Hopkins University Press.
- Kraybill, D., & Olshan, M. A. (1994). *The Amish struggle with modernity*. Hanover, NH: University Press of New England.
- Kreps, G., & Kreps, M. (1997). Astonishing "medical care." *Journal of Multicultural Nursing and Health*, 3(2), 44-47.
- Langin, B. G. (1994). *Plain and Amish: An alternative to modern pessimism*. Scottdale, PA: Herald Press.
- Leininger, M. M. (1970). *Nursing and anthropology: Two worlds to blend*. New York, NY: John Wiley & Sons.
- Leininger, M. M. (1985). *Qualitative research methods in nursing*. Philadelphia, PA: W.B. Saunders.
- Leininger, M. M. (1991). *The theory of culture care diversity and universality*. New York, NY: National League for Nursing.
- Leininger, M. M. (1995). *Transcultural nursing: Concepts, theories, research, & practices* (2<sup>nd</sup> ed.). New York, NY: McGraw Hill.
- Leininger, M. M. (2002). Culture care theory: A major contribution to advance transcultural nursing knowledge and practices. *Journal of Transcultural Nursing*, 13(3), 189-192.

- Leininger, M. M., & McFarland, M. R. (2002). *Transcultural nursing: Concepts, theories, research, & practices* (3<sup>rd</sup> ed.). New York, NY: McGraw Hill.
- Leininger, M. M., & McFarland, M. R. (2006). *Culture care diversity and universality: A worldwide nursing theory*. Sudbury, MA: Jones and Bartlett.
- Lemon, B. S. (2002). Amish health care beliefs and practices in an obstetrical setting. *The Journal of Multicultural Nursing & Health*, 8(3), 72-77.
- Mason, W. C. (2002). *Dimensions of servant-leadership in American not-for profit hospitals*. Unpublished doctoral dissertation, University of North Florida, Jacksonville.
- Maxwell, J. C. (2001). *The 17 indisputable laws of teamwork: Embrace them and empower your team*. Nashville, TN: Thomas Nelson.
- Mechanic, D. (1978). *Medical sociology* (2nd ed.). New York, NY: Free Press.
- Merriam-Webster Online Dictionary & Thesaurus. (2005). Accessed November 20, 2005, from <http://www.m-w.com/>.
- Meyers, T. J. (1994). Education and schooling. In D. Kraybill (Ed.), *The Amish and the State* (pp. 87-106). Baltimore, MD: Johns Hopkins University Press.
- Miller, N. L. (1997). Childbearing health practices as described by Old Order Amish women. *Dissertation Abstracts International*, 36(04). (UMI No. AAG1388555)
- Morse, J. M. (1994). *Critical issues in qualitative research methods*. Thousand Oaks, CA: Sage.
- Nelson, W. A. (1999). A study of Amish women's construction of health narratives. *Dissertation Abstracts International*, 60(1), 07A. (UMI No. AAG9939725)
- Nolt, S. M. (1992). *A history of the Amish*. Intercourse, PA: Good Books.
- O'Neil, D. J. (1997). Explaining the Amish. *International Journal of Social Economics*, 24(10), 1132-1128.
- Orque, M. (1983). Orque's ethnic/cultural system: A framework for ethnic nursing care. In M. Orque, B. Blach, & L. S. A. Monrroy (Eds.), *Ethical nursing care: A multicultural approach* (pp. 5-48). St Louis, MO: C.V. Mosby.
- Palmer, C. V. (1992). The health beliefs and practices of an Old Order Amish family. *Journal of the American Academy of Nurse Practitioners*, 4(3), 117-122.



- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). London, England: Sage.
- Peoples, J., & Bailey, G. (2000). *Humanity: An introduction to cultural anthropology*. Belmont, CA: Wadsworth/Thomson Learning.
- Polit, D. F., Beck, C. T., & Hungler, B. P. (2001). *Essentials of nursing research, methods, appraisal, and utilization* (5th ed.). New York, NY: J.B. Lippincott, Williams, & Wilkins.
- Purnell, L. D. (1999). Panamanians' practices for health promotion and the meaning of respect afforded them by health care providers. *Journal of Transcultural Nursing*, 10(4), 331-339.
- Purnell, L. D. (2002). The Purnell model for cultural competence. *Journal of Transcultural Nursing*, 13(3), 193-196.
- Purnell, L. D., & Paulanka, B. J. (Eds.). (1998). *Transcultural health care: A culturally competent approach*. Philadelphia, PA: F.A. Davis Company.
- Purnell, L. D., & Paulanka, B. J. (2003). The Purnell model for cultural competence. In L. D. Purnell & B. J. Paulanka (Eds.), *Transcultural health care: A culturally competent approach* (2nd ed., pp. 8-39). Philadelphia, PA: F.A. Davis Company.
- Reynolds, C. L., & Leininger, M. M. (1993). *Madeleine Leininger: Culture care diversity and universality theory*. Newbury Park, CA: Sage.
- Richardson, L. (1990). *Writing strategies: Reaching diverse audiences* (Qualitative Research Methods Series 21). Newbury Park, CA: Sage.
- Rosenbaum, J. (1990). Culture care of older Greek Canadian widows within Leininger's theory of culture care. *Journal of Transcultural Nursing*, 2 (1), 37-48.
- Rosenstock, I. M. (1974). *The health belief model and preventive health behavior*. Thorofare, NJ: Charles B. Slack.
- Russell, R. F. (2000). *Exploring the values and attributes of servant leaders*. Unpublished master's thesis, Regent University, Virginia Beach, VA.
- Schultz, E. A., & Lavenda, R. H. (1998). *Cultural anthropology: A perspective on the human condition*. Mountain View, CA: Mayfield Publishing Company.
- Schwartz, T. (1995). *What really matters: Searching for wisdom in America*. New York, NY: Bantam Books.

- Schwartz, K. S. (2002). *Breast cancer and health care beliefs, values, and practices of Amish women*. Unpublished doctoral dissertation, Wayne State University, Detroit, MI.
- Shen, M. (2004). Cultural competence models in nursing: A selected annotated bibliography. *Journal of Transcultural Nursing*, 15(4), 317-322.
- Spears, L. (Ed.). (1998). *The power of servant leadership: Essays by Robert K. Greenleaf*. San Francisco, CA: Berrett-Koehler.
- Spears, L. C., & Lawrence, M. (2002). *Focus on leadership: Servant-leadership for the 21st century*. New York, NY: John Wiley & Sons.
- Spector, R. E. (2004). *Cultural diversity in health and illness* (6th ed.). Upper Saddle River, NJ: Prentice Hall.
- Spradley, J. P. (1970). *The ethnographic interview*. Fort Worth, TX: Harcourt Brace Jovanovich College.
- Stake, R.E. (1995). *The art of case study research*. Thousand Oaks, CA: Sage.
- Varney, H. (1987). *Nurse midwifery* (2nd ed.). Boston, MA: Blackwell Scientific.
- Wenger, A. F. (1988). The phenomenon of care in a high context culture: The Old Order Amish. *Dissertation Abstracts International*, 50(01), 02B. (UMI No. AAG89-10384).
- Wenger, A. F. (1993). Cultural meaning of symptoms. *Holistic Nurse Practitioner*, 7(2), 22-35.
- Wenger, A. F. (1995). Cultural context, health, and health care decision making. *Journal of Transcultural Nursing*, 7(1), 3-14.
- Wenger, A. F., & Wenger, M. R. (1998). The Amish. In L.D. Purnell & B.J. Paulanka (Eds.), *Transcultural health care: A culturally competent approach* (pp. 75-105). Philadelphia: F. A. Davis.
- Wenger, M. R. (1970). *A Swiss German dialect study: Three linguistic islands in midwestern USA*. Ann Arbor, MI: University Microfilms.
- Weyer, S., Hustey, V. R., Rathbun, L., Armstrong, V. L., Anna, S. R., Ronyak, J., & Savrin, C. (2003). A look into the Amish culture: What should we learn? *Journal of Transcultural Nursing*, 14(2), 139-145.
- Wheatley, M. J. (1999). *Leadership and the new science revised: Discovering order in a chaotic world*. San Francisco, CA: Berrett-Koehler.

- Wittig, D. R. (2004). Knowledge, skills, and attitudes of nursing students regarding culturally congruent care of Native Americans. *Journal of Transcultural Nursing*, 15(1), 54-61.
- Yoder, K. (1984). Influence of cognitive style on an American subculture's health seeding behavior and view of nurses. *Dissertation Abstracts International*, 45(1), 02A. (UMI No. AAG84-12287)
- Yoder, K. (1997). Nursing intervention considerations among Amish older persons. *Journal of Multicultural Nursing & Health*, 3(2), 48-52.

## VITA

## VITA

Victoria L. Wickwire  
9488 Park Ridge Trail  
Berrien Center, MI 49102  
Wickwire @andrews.edu  
269-471-9417

### Academic Degrees

Ph.D.	Andrews University	2006	School of Education, Leadership & Educational Administration
MSN	Case Western Reserve University	1996	Masters of Nursing Science
CNM	Frontier School of Midwifery Family Nursing	1993	Certified Nurse-Midwifery
BSN	Eastern Ky. University	1990	Bachelors of Nursing Science
A.A.	Prince George's College	1974	Associate of Arts in Nursing

### Professional Experience

2003-Present	CEO of Versatile Management LLC, Berrien Center, MI. Part-time volunteer consulting and health ministries work in Transcultural Nursing in Papua New Guinea, Philippines, China, and Europe.
1997-2003	Assistant Professor of Nursing, Director of Undergraduate Programs, and Associate Chairperson, Andrews University, Berrien Springs, MI. Also full time teaching, clinical supervision of nursing students, and part-time clinical practice in Midwifery.
1993-1997	Certified Nurse Midwife at a rural health care clinic and hospital in Appalachia, Manchester, Kentucky. Member of Medical Staff and Obstetrical Committee.
1978-1993	House Nursing Supervisor, Obstetrical Unit Coordinator, for Manchester Memorial Hospital, Manchester, Kentucky.
1975-1978	Neonatal Intensive Care nurse at Bethesda Naval Medical Center, Bethesda, Maryland.
1974-1975	Nurse Supervisor in Internal Medicine practice of Dr. Walcutt Gibson, Washington, D.C.